Kevin M. Mosier, MD
Patrick A. Webster, PA-C

Southeast Kansas Orthopedic Clinic
1902 S Hwy 59, Bldg D
Parsons, KS 67357
(620) 421-0881

Brad R. Meister, MD
John K. Taber, PA-C

Patient Name: _____ SS #: _____

Address/City _____ **Employed?** ☐ Yes ☐ No **Employer**: _____
State/Zip
_____ Primary Care Physician: _____

Date of Birth: _____Age:_____ Specialty Physician :_____

Phone Numbers Emerg. Contact: _____

Home: _____ Emerg. Contact Ph#: _____

Cell:_____

Work:_____ (Select one) Right-Handed ☐ or Left-Handed ☐

Email:_____Portal: Yes ☐ No ☐ Preferred Pharmacy: _____

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐ **Spouse Name/Ph#:**_____

Advance Care Planning: Do you have a healthcare proxy in the event you are unable to make your own medical decisions?
YES ☐ **NO** ☐
Designee's Name:_____ Contact phone number: _____

Insurance Information:_____ID#:_____

PolicyHolder:_____ DOB:_____Relationship:_____

Responsible Party:_____Phone:_____Relationship:_____

Accident/ Injury Information

Is office visit due to an accident or injury? ☐ **YES /NO** ☐ **(If you answered "NO" please stop and continue to page 2 (**Health History.**)**

*****If you answered "YES" please complete the entire accident/injury section.*****

Date of accident/injury: _____ How did accident/injury occur?_____

Body Part:_____

WHERE did accident/injury occur? School ☐ Work ☐ Home ☐ Other:_____

Was the accident/injury work/school related: YES ☐ NO ☐

Employer/ School:_____Occupation:_____Phone#:_____

Was the injury the result of a motor vehicle accident or of physical contact with a motor vehicle? YES ☐ NO ☐

*If YES, what type of vehicle was involved? CAR/TRUCK ☐ MOTORCYCLE ☐

Was another party responsible for your injury or condition? YES ☐ NO ☐

If "YES" please explain:_____

Southeast Kansas Orthopedic Clinic

Health History Questionnaire

Social History

Use of Alcohol: ☐ YES or NO ☐ Occasional ☐ Social ☐ Daily ☐

How many times in the past year have you had 5 or more drinks in a day for men, OR 4 or more drinks in a day for women OR any adult older than 65? Choose a number between 0 and 365 _____

Use of Tobacco: ☐ YES or NO ☐ or FORMER ☐ Smoke/Vape ☐ or Chew ☐ Average Packs/Day: ___

Use of Street Drugs: ☐ YES or NO ☐ Living Situation: Alone ☐ Family ☐ Friend ☐ Other ☐

****PLEASE PROVIDE LIST OF MEDICATIONS AT CHECK-IN**or list below any prescription and/or non-prescription medications you are currently taking. Include vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives or cold medications. Please also include any diet medications you are taking (prescription or over the counter). Attach separate page if needed.**

Name of Medication / Dosage:

_____

_____

_____

_____

Medication Allergies- Please list medications to which you had hives, skin rash, breathing problems or other allergic reactions.

Name of Medicine: _____

_____

_____

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SOUTHEAST KANSAS ORTHOPEDIC CLINIC
Notice of Privacy Practices Summary /Financial Acknowledgement

Maintaining privacy of your health information is very important to us. We encourage you to read the entire Notice and ask any questions you may have regarding its contents. You may read our Notice of Privacy Practices in person or request a copy via email or mail.

The ultimate responsibility for payment lies with the patient/guarantor. Payment for services is due at the time of service unless payment arrangements have been approved in advance. It is the responsibility of the patient to provide current insurance information at the time of appointment and verify that we are participating providers in your network. Not providing this information in a timely fashion may result in services being patient financial responsibility.

I acknowledge that I have received, or been given the opportunity to receive, a copy of my provider's Notice of Privacy Practices with the effective date of April 14th, 2003. (revised March 25, 2013).

We are committed to providing you with the best possible care. The ultimate responsibility for payment lies with the patient/guarantor. Payment for services is due at the time of service unless payment arrangements have been approved in advance. As a courtesy, Southeast Kansas Orthopedic Clinic will submit claims to insurance companies for payment of services. All non-covered services, deductibles, coinsurance, and co-pays are the patient's financial responsibility.
I hereby assign all medical benefits to include major medical benefits to which I am entitled, including private insurance and other health plans to Kevin M Mosier, MD, Brad R Meister, MD, and/or their physician extenders.

Consent for Health Care: Patient voluntarily consents to such medical care including but not limited to laboratory, diagnostic or medical treatment which may be ordered by the patient's physician or assistants, or designees for medical treatment which they may deem necessary and advisable.
The agreements and assignments will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an original. I, the undersigned, authorize Kevin M Mosier, MD, Brad R Meister, MD, and/or their physician extenders to release any information acquired in the course of my examination or treatment to my insurance company (s), another physician or agents or employees of Southeast Kansas Orthopedic Clinic for the purposes of business operations, payment for health care services rendered and continual treatment or coordination of care.

_____ _____

Signature of Patient / Patient Rep. (relationship) *Date*

SEK Ortho Use Only

A good faith effort was made to obtain a written acknowledgment of his / her receipt of the Notice, but such acknowledgement could not be obtained because:

- ☐ Patient / Personal Representative refused to sign.
- ☐ Patient / Personal Representative was unable to sign.
- ☐ The Patient had a medical emergency and an attempt to obtain the acknowledgement will be made at the next available opportunity.
- ☐ Other reason (please specify):_____
  _____

_____ _____

Signature of SEK Ortho Staff *Date*

Kevin M. Mosier, MD
Patrick A. Webster, PA-C

Southeast Kansas Orthopedic Clinic

HIPAA Privacy Authorization Form

Brad R. Meister, MD
John K. Taber, PA-C

Authorization for use or Disclosure of Protected Health Information

1. I hereby authorize SEK Ortho to use and/or disclose my protected health information ("PHI") described below.

2. I hereby authorize the release of my PHI which may include the following examples:
   - Appointment dates and times
   - Tests that have been received
   - Test results
   - Other health information

3. In addition to the authorization for release of my PHI described in section 2 of this authorization, I authorize disclosure of information regarding my billing, condition, treatment, and prognosis to the following individual(s):

Name: _____ ***Relationship:*** _____
_____ ***Telephone:*** _____

Name: _____ ***Relationship:*** _____
_____ ***Telephone:*** _____

Name: _____ ***Relationship:*** _____
_____ ***Telephone:*** _____

4. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing, or claims payment, or other purposes as I may direct.
5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.
6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient *Date*

_____ _____
Print Patient Name *Date of Birth*

Southeast Kansas Orthopedic Clinic Medication Agreement

Kevin M. Mosier, M.D.
Brad R. Meister, M.D.
Patrick A. Webster, PA-C
John K. Taber, PA-C

Welcome to the Southeast Kansas Orthopedic Clinic, we appreciate that you chose us to provide care for your orthopedic needs. There are times as a patient being seen at this facility you will be given prescriptions for anti-inflammatory or pain medication. Legislation has placed many new restrictions on these medications, and we are taking all measures to reduce your reliance on this type of treatment.

Here are some guidelines associated with these medications that you should be aware of:

1. **If you are prescribed an anti-inflammatory medication** such as meloxicam (Mobic), celecoxib (Celebrex) or diclofenac (Voltaren), we will only prescribe these for 4-6 weeks maximum. If you find you have good relief from these medications, further refills will need to be refilled by your PCP (primary care physician). These medications require your kidney function to be monitored regularly.

2. **If you are prescribed pain medication** such as Tramadol, Hydrocodone, or Oxycodone these medications will only be prescribed for a short duration. Post-operative pain meds will be refilled for up to 6 weeks. We do not prescribe pain medication prior to surgery.

3. **Refills**. Please contact us **a minimum of 2 DAYS IN ADVANCE** during normal business hours Monday- Thursday if you need a refill. EVERY WEDNESDAY, PLEASE COUNT YOUR PILLS TO ENSURE THAT YOU HAVE ENOUGH TO GET YOU THROUGH THE WEEKEND. Please allow 24-48 hours for pain medication refills.

Thank you for your attention to this matter. We look forward to helping you in your recovery process regarding your orthopedic needs.

_____ _____

Patient name Patient date of birth

_____ _____

Signature of Patient/ Patient Representative Date

_____

Relationship to Patient

08/13/2024

Attention: SEK Ortho staff- Add patient flag to account!