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: (PRIMARY)_____ (SECONDARY)_____

SOCIAL SEC #:_____ DATE OF BIRTH:_____

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

PREFERRED PRONOUNS: _____

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 _____ SUBSCRIBER ID_____

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

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_____

2331 Tuttle Creek Blvd, 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*

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

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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?_____

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_____ _____
male female

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
	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 Medical Records to be released

To: Name: CenterPointe Physians, PA
Address: 2331 Tuttle Creek Blvd
Manhattan, KS 66502
Phone: 785-537-4940
Fax: 785-537-0836

From: Name_____
Address_____
_____
Phone_____
Fax_____

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 gonorrhea.

☐ 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 nay the recipient (except as noted above), and this redisclosure may no longer be protected by federal or state law.