Mark R Killman, M.D.
EMG Specialist
PHONE: (816) 254-9595 FAX: (816) 836-3810

□ Centerpoint Medical Center
19550 E 39th St. Ste. 415
Independence, MO 64057
(Centerpoint Medical Office Building)

□ Western MO Bone & Joint
510 Foster Lane, Ste. 101
Warrensburg, MO 64093

PLEASE READ THE FOLLOWING MATERIAL CAREFULLY

You have an appointment on _____ at _____ with Dr. Killman.

Please bring the following:

- ✓ Your insurance card(s) and any co-pay you have for a specialist
- ✓ This packet, with forms filled out completely and ready to give to our office staff

We discourage patients from bringing small children to their appointment. We do not allow children in the examination rooms.

Please notify our office within 24 hours if you are unable to keep your appointment or need to reschedule.

If you show up later than 10 minutes after the start of your appointment, you may need to be rescheduled.

If you should have any questions, please feel free to call us at the number above.

We look forward to serving your medical needs!

There will be a cancellation fee of $50 that will be charged to the patient if an appointment is cancelled with less than 24 hours notice or for no-shows.
This fee is billed directly to the patient and not the insurance company.

PATIENT INFORMATION SHEET

PERSONAL INFORMATION:

NAME: _____ SSN#: _____
(Last) (First) (MI)

MAILING ADDRESS: _____

_____
(City) (State) (Zip)

HOME PHONE: _____ WORK PHONE: _____

CELL: _____

DATE OF BIRTH: _____ SEX: _____ MARITAL STATUS: _____

NAME OF EMPLOYER: _____ SELF EMPLOYED? Y I N

EMPLOYER'S ADDRESS: _____
(Number & Street) (City) (State) (Zip)

NEAREST RELATIVE/FRIEND: _____ RELATIONSHIP: _____
(Not living with you)

ADDRESS: _____ PHONE: _____

INSURANCE INFORMATION:

NAME OF INSURED: _____ INSURED'S BIRTHDAY: _____

NSURANCE NAME: _____PHONE: _____

CLAIMS ADDRESS: _____

POLICY #: _____ GROUP #: _____ ADJUSTOR: _____

SECONDARY INSURANCE: Y I N INSURANCE NAME: _____

CLAIMS ADDRESS: _____

POLICY #: _____ GROUP #: _____ ADJUSTOR: _____

I authorize *Mark R. Killman, MD*, to release information regarding my medical care to my insurance company to process my claim. I authorize payment of benefits to *Mark R. Killman, MD*, for all services rendered. I understand that I will be responsible for any balance not covered by my insurance company. In the event my account should go to collection, I understand that I will be responsible for any and all collection and legal fees.

_____ _____
SIGNATURE OF INSURED/AUTHORIZED PERSON **DATE**

MARK R. KILLMAN, M.D., P.C.
PHYSICAL MEDICINE AND REHABILITATION

EMG
Patient History Form

Name: _____ Age: _____ Height: _____ Weight: _____

Reason For Visit/Chief Complaint or Symptoms: _____

_____

_____

Date of Onset: _____

PLEASE LIST SIGNIFICANT PAST MEDICAL HISTORY/ILLNESSES:

_____

_____

_____

Specifically, do you have a history of Diabetes: Y I N

Which is your dominant hand? Left I Right

SURGERY HISTORY: Specifically, have you had any surgery on your neck, back, arms or legs?

_____

_____

MEDICATION:

Area you currently taking any blood thinners? (i.e. Coumadin) Y I N

If yes, please list: _____

ALLERGIES: _____

_____

SOCIAL HISTORY:

Occupation/Work History: ☐ Full Time ☐ Part Time ☐ Off Work ☐ Retired

Job Title: _____

Describe Duties: _____

_____

_____

MARK R. KILLMAN, M.D., P.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I HEREBY GIVE MY CONSENT FOR MARK R. KILLMAN, M.D., P.C., TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT ME TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

I hereby acknowledge my right to review the Privacy Practices for Mark R. Killman, M.D., P.C. prior to signing this consent.

With this consent, Mark R. Killman, M.D., P.C. may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operation, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Mark R. Killman, M.D., P.C. may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient billing services.

By signing this form, I am consenting Mark R. Killman, M.D., P.C.'s use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke, Mark R. Killman, M.D., P.C. may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian