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

☐ **Centerpoint Medical Center**
19550 E. 39th Street, Suite 415
Independence, MO 64057
(Centerpoint Medical Offices)

☐ **OSI**
8250 N. Church Road
Kansas City, MO 64158

☐ **Encompass**
7020 W. 121st Street
Leawood, KS 66209

☐ **Sedalia**
3700 W. 10th Street Suite 301
Sedalia, MO 65301
(Bothwell Healing Arts Center)

PLEASE READ THE FOLLOWING MATERIAL CAREFULLY

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

Please bring the following with you to your appointment:

- ✔ Insurance card(s) and any co-pay you have for a specialist.
- ✔ Picture ID
- ✔ 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 staff within 24 hours if you are unable to keep your appointment or need to reschedule.

If you are later than 10 minutes for your appointment, you may need to be rescheduled.

If you should have any questions, feel free to call us at 816-254-9595.

We look forward to serving your medical needs.

*** There will be a cancellation fee of $50 that will be charged to the patient if the appointment is canceled within 24 hours of the appointment time. The fee will be billed to the patient and not the insurance company.**

PATIENT INFORMATION SHEET

PERSONAL INFORMATION:

Name:_____SS#_____
(LAST) (FIRST) (MI)

MAILING ADDRESS:_____

_____
(CITY) (STATE) (ZIP CODE)

HOME TELEPHONE: (____) _____WORK TELEPHONE:(____)_____

CELL (____)_____

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

NAME OF EMPLOYER:_____ SELF EMPLOYED: (YES) (NO)

EMPLOYERS ADDRESS:_____
(NUMBER AND STREET) (CITY) (STATE) (ZIP CODE)

NEAREST RELATIVE/FRIEND:_____RELATIONSHIP:_____
(NOT LIVING WITH YOU)

ADDRESS:_____PHONE NUMBER:_____

INSURANCE INFORMATION:

POLICY HOLDER NAME:_____ POLICY HOLDER DATE OF BIRTH:_____

NAME OF INSURANCE:_____PHONE NUMBER:_____

ADDRESS FOR CLAIMS:_____

POLICY NUMBER:_____GROUP NUMBER:_____ADJUSTER:_____

IS THERE A SECONDARY INSURANCE: (YES) (NO) INSURANCE NAME:_____

ADDRESS FOR CLAIMS:_____

POLICY NUMBER:_____GROUP NUMBER:_____PHONE NUMBER:_____

I authorize Mark R. Killman, M.D., P.C. to release information regarding my medical care to my insurance company to process my claim. I authorize payment of benefits to Mark R. Killman, M.D. 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 I will responsible for any and all collection and legal fees.

_____ _____
SIGNATURE OF INSURED/AUTHORIZED PERSON (DATE)

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

EMG
PATIENT HISTORY FORM

Name:_____Age:_____Height:_____Weight:_____

Reason for visit/chief complaint/symptoms:_____
_____
_____
_____

Date of onset:_____

PLEASE LIST SIGNIFICANT PAST MEDICAL HISTORY/ILLNESSES:
_____
_____
_____

Do YOU have a history of diabetes? ☐ YES ☐ NO

Which is your dominant hand? Left Right

SURGICAL HISTORY:
Have you had any surgery on your neck, back, arms or legs?
_____
_____

MEDICATION:
Are you currently taking any blood thinners? (i.e. Coumadin) ☐ YES ☐ NO
If yes, please list:_____

ALLERGIES:_____

SOCIAL HISTORY:

Occupational/work history: ☐ Full Time ☐ Part Time ☐Unemployed ☐ Retired

Job Title:_____

Job 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 voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care.

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 statements.

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

_____

Printed Name of Patient or Legal Guardian