LORI ANN GOLON, MD PA
PH (913)682-3920 1001 6TH AVE, SUITE 210 FAX (913)682-6239
LEAVENWORTH, KS 66048

PLEASE PRINT	PATIENT INFORMATION	DATE	
Patient (Last Name)	(First Name)	(Middle)	Race
SSN	Date of Birth	Age	Sex
Address (Street)	City	State	Zip
Home Ph	Cell Ph	Referred by	Pharmacy *(Primary)*

Father (First, Last)	Address	Home Ph	Work Ph	Cell Ph
Mother (First, Last)	Address	Home Ph	Work Ph	Cell Ph

RESPONSIBLE PARTY/PRIMARY GUARANTOR

Last Name	First	Middle	Date of Birth	SS#
Address, City, State, Zip	Relationship to Patient	Home Ph: Work/Cell Ph:		Marital:
Employer	Employer's Address (City State, Zip)			
Signature of Legal Guardian or Responsible Party	Date	Email Address:		

INSURANCE INFORMATION

Primary Insurance Company	Policy Number	Group Number	Employer
Primary Ins Policy Holder Name (First, Last, Middle Initial)	SS #	Date of Birth	
Secondary Insurance Company	Policy Number	Group Number	Employer
Secondary Ins Policy Holder Name (First, Last, Middle Initial)	SS#	Date of Birth	

Emergency Contact Information

Name (First, Last, Middle Initial)		Home Ph:	Work/Cell Ph:
Address	City	State, Zip	Relationship:

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: ______________________________ DATE: ______________

DR. LORI ANN GOLON MD PA

Patient Name: ________________________________ DOB: _______________

Late Cancellation/Missed Appointment Policy

At our office, our goal is to provide our patients with quality medical care. To do that, we have a Late Cancellation/Missed Appointment policy. This enables us to better utilize available appointments for our patients in need of medical care.

Cancelling your appointment:

Please be respectful of the medical needs of other patients by calling our office if you are unable to attend your appointment. This time can then be given to another patient in need of medical care. If it is necessary for you to cancel your appointment, we require that you call at least 24 hours in advance. Because appointments are high in demand, your early cancellation will give another patient the opportunity to have access to timely care. If you need to cancel your appointment just call our office at 913-682-3920 and speak to our receptionist, or if they cannot be reached, leave a detailed message including the patient's name and date of birth on the voicemail. Late cancellations WILL be considered as a "no-show."

No show policy:

A "no-show" is a missed appointment without 24 hours' notice. "No-shows" inconvenience other patients who need medical attention. They also represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. The office manager or receptionist will counsel you after one "no-show," and any subsequent "no-show" can lead to your dismissal from our practice.

I have read the above policy completely. I agree to all the terms and understand that if I violate this policy it may result in the termination of my child's doctor/patient relationship.

Signed: ____ Date: ______________

CONSENT AND AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I ____ born______________
date of birth)

Consent and authorize____
(name of facility)

to send the following patient records to:

Lori Ann Golon M.D.P.A F.A.A.P

Cushing Medical Plaza
1001 6th Ave Suite 210
Leavenworth, Kansas 66048
Ph: 913-682-3920
Fax: 913-682-6239

☐ All of my patient records *EXCEPT* those relating to care and treatment for mental health conditions, drug or alcohol abuse, HIV testing, infection status or care and treatment for AIDS.

☐ All of my patient records *INCLUDING* the following:

Care and treatment for mental health conditions
Care and treatment for drug or alcohol abuse
Care and treatment related to HIV testing, infection status and treatment for AIDS

I understand this consent and authorization may be revoked at any time except to the extent already acted upon. This consent and authorization expires on ________ or after 90 days of the date signed if I have not provided an expiration date.

A photo static copy of this consent and authorization shall be considered as effective and valid as the original.

____________________________________ ________________
Signature of Patient or Legal Representative Date Signed

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

LORI ANN GOLON M.D. P.A.

I understand that I have certain rights to privacy regarding my protected health information. By signing this notice, I am stating that I have received, read and understood your NOTICE OF PRIVACY PRACTICES which contains a more complete description of the uses and disclosures of my health information or have been offered and declined my right to a copy of the notice.

Date: ______________________

____

Patient Name

____

Parent or Guardian Signature

TELEHEALTH INFORMED CONSENT

Lori Ann Golon, M.D.

Jenae Hesse, MSN

APRN, NP-C

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

Patient's Initials

_____ I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.

_____ I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

_____ I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of Kansas at the time of this service.

_____ I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.

_____ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
- *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*
- *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*

_____ I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.

_____ I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

_____ I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

_____ I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

_____ The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

_____ I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

_____ I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.

_____ I understand that electronic communication cannot be used for emergencies or time-sensitive matters.

_____ I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.

_____ I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.

_____ By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

_____ I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.

_____ To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.

_____ I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

For electronic communication between Lori Ann Golon, MD and staff and ______________________.

____ Patient or Legal Representative Signature/Date/Time

_______________________ Relationship to Patient Print

________________________________ Patient or Legal Representative Name

_________________________ Witness Signature/Date/Time

I certify that I have explained the nature of this agreement to the patient/patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

__________________________________ Healthcare Provider Signature/Date/Time

__________ copy given to patient
initial

__________ original placed in chart
initial

Optional National Emergency Crisis Language

I understand that due to the state of the current national emergency crisis, telehealth is offered by

_______________ to appropriate patients to comply with federal and state mandates of isolation

and social distancing as an effort to provide protection to everyone.

The purpose of this form is to obtain your consent for a telehealth visit with one of our healthcare providers at the office of Lori Ann Golon, MD.

The purpose of this visit is for the care of __________________________ during the national emergency.

DR. LORI ANN GOLON MD PA

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

The organization listed above will use and distribute the Notice as their Joint Notice of Privacy Practices and follow the information practices described in this Notice when disclosing records and information. They will share your health information with each other, as necessary, to carry out treatment, payment, or health care operations as described in this notice.

Understanding Your Health Information

Each time you visit a hospital, clinic, physician, or other health care provider, a record of your visit is made. Typically, this health record contains your medical history, symptoms, examination and test results, diagnosis, treatment, care plan, insurance, billing, and employment information. This health information often referred to as your health record, serves as a basis for planning your care and treatment and is a vital means of communication among many health professionals who contribute to your health care. Your health information is also used by insurance companies and other third-party payers to verify the appropriateness of billed service.

Our Responsibilities

We are required by law to:

- Maintain the privacy of your health information.
- Provide you with an additional current copy of our Notice upon request.
- Abide by the terms of our current Notice.

We will not use or disclose your health information without your written authorization, except as described in this Notice. Such authorization may be revoked in writing at any time except with respect to any actions we have taken in reliance on it.

Examples of Using Health Information for Treatment, Payment and Health Care Operations

We will use and disclose your health information for treatment purposes.
For example: Information obtained by a nurse, physician or other member of your health care team will be recorded in your record and used to determine the course of treatment. Health care team members will communicate with one another personally and through the health record to coordinate care provided. We will also provide your physician or

subsequent health care provider with copies of various reports that should assist him or her in treating you in the future.

We will use and disclose your health information for payment purposes.
For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. We may disclose health information about you to other qualified parties for their payment purposes. For example, if you are brought in by ambulance, we may disclose your health information to the ambulance provider for its billing purposes.

Health Information Exchange
We may make your protected health information available electronically through an information exchange service to other health care providers, health plans and health care clearinghouses that request your information. Participation in information exchange services also lets us see their information about you.

Other Uses and Disclosures of Your Health Information

Notification
We may use or disclose health information to notify or assist in notifying a family member, personal representative, or another person responsible for your care of your location and general condition.

Communication With Family and Others
We may disclose relevant health information to a family member, friend, or other person involved in your care. We will only disclose this information if you agree, are given the opportunity to object and do not, or if in our professional judgment, it would be in your best interest to allow the person to receive the information or act on your behalf.

Appointment Reminders
We may contact you as a reminder that you have an appointment for treatment or medical care.

Public Health
We may disclose health information about you for public health activities. These activities may include disclosures:

- To a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability;
- To appropriate authorities authorized to receive reports of abuse and neglect;
- To FDA-regulated entities for purposes of monitoring or reporting the quality, safety or effectiveness of FDA-regulated products; or

To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Correctional Institutions
If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose to the correctional institution, its agents or the law enforcement official your health information necessary for your health or the health and safety of other individuals.

Law Enforcement
We may disclose health information if asked to do so by a law enforcement official as required or permitted by law or in response to a subpoena.

Health Oversight Activities
We may disclose health information for health oversight activities authorized by law. For example, oversight activities include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Threats to Health or Safety
Under certain circumstances, we may use or disclose your health information if we believe it is necessary to avert or lessen a serious threat to health and safety and is to a person reasonably able to prevent or lessen the threat or is necessary for law enforcement authorities to identify or apprehend an individual involved in a crime.

Specialized Government Functions
We may disclose your information for national security and intelligence activities authorized by law, for protective services of the president; or if you are a military member, to the military under limited circumstances.

As Required by Law
We will use or disclose your health information as required by federal, State or local law.

Lawsuits and Administrative Proceedings
We may release your health information in response to a court or administrative order. We may also provide your information in response to a subpoena or other discovery request, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Funeral Directors, Medical Examiners, and Coroners
We may disclose your health information to funeral directors, medical examiners, and coroners consistent with applicable law to carry out their duties.

Organ Procurement Organizations
Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Your Health Information Rights

You have the following rights regarding your health information:

Right to Inspect and Copy
You may request to look at your medical and billing records and obtain a copy. You must submit your medical records request to the Medical Records Department. Contact the office listed on your billing statement to request a copy of your billing record. If you ask for a copy of your records, we may charge you a copying fee plus postage. If we maintain an electronic health record about you, you have the right to request your copy in electronic format.

Right to Request Amendment
You may request that your health information be amended if you feel that the information is not correct. Your request must be in writing and provide rationale for the amendment. Please send your request to the Medical Records Department. We may deny your request, and will notify you of our decision in writing.

Right to an Accounting of Disclosures
You may request an accounting of certain disclosures of your health information showing with whom your health information has been shared (does not apply to disclosures to you, with your authorization,.for treatment, payment or health care operations, and in certain other cases).

To request an accounting of disclosures, you must send a written request to the Medical Records Department. Your request must state a time period that may not be longer than six years.

Right to Request Restrictions
You may request restrictions on how your health information is used for treatment, payment or health care operations, or to certain family members or others who are involved in your care. We may deny your request with one exception. We must approve your request if you have paid out-of-pocket in full for all expenses for a particular item or service. If we agree to a restriction, the restriction may be lifted if use of the information is necessary to provide emergency treatment.

To request a restriction, you must send a written request to the Medical Records Department, specifying what information you wish to restrict and to whom the restriction applies. You will receive a written response to your request.

Right to Request Private Communications
You may request that we communicate with you in a certain way in a certain location. You must make your request in writing to the patient registration area and explain how or

where you wish to be contacted.

Right to a Paper Copy of this Notice
You may request an additional paper copy of this Notice at any time from any patient registration area.

You may contact the Medical Records Department at:

Lori Ann Golon MD PA
1001 6th Avenue, Suite 210
Leavenworth, KS 66048

Changes to this Notice
We reserve the right to change this Notice as our privacy practices change and to make the new provisions effective for all health information we maintain. We will post a current Notice in patient registration areas and on our websites.

For More Information or to Report a Problem
If you have questions or would like additional information, you may contact our office manager. If you believe your privacy rights have been violated, you may file a complaint with our office manager or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

DR. LORI ANN GOLON MD PA

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