KU SCHOOL OF MEDICINE-WICHITA
MEDICAL PRACTICE ASSOCIATION
The University of Kansas

SOP/ASA Student INFORMATION

Social Security Number:	Student Email:
Name:	Marital Status:
Address:	Student Status: FT / PT / Not a student
City:	Primary Care Physician:
State: Zip:	Preferred Hospital:
Home Phone Number:	**No Insurance:** Yes / No **Self Pay:** Yes / No
Work Phone Number:	**Primary Insurance:**
Cell Phone Number:	ID #:
Sex:	Group #:
Date of Birth:	Subscriber:
Race: American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / White / Declined	Employer:
Ethnicity: Hispanic or Latino / Refused / Not Hispanic or Latino	Subscriber Birthdate:
Preferred Language:	Subscriber SSN:
Employment: FT / PT / Self / Military / Unemployed / Retired	Relationship to Student: Self / Spouse / Dependent / Other

DISCLOSURE

I understand that it is my right to elect to whom my medical, insurance and/or financial information can be released. For our records the first person listed will be your emergency contact. I also understand that if I choose to leave this information blank, the facility will not have an emergency contact or be able to release any information to anyone including my spouse/significant other, children, parents, siblings, etc. I therefore authorize KUSM-W Medical Practice Associate to release my information as directed below.

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

AUTHORIZATION

I do hereby authorize the release of any medical information necessary to process claims on my behalf. I request that all insurance benefits be paid directly to KUSM-W Medical Practice Association for all charges incurred by me. I understand that I am responsible for all charges incurred during my treatment at KUSM-W Medical Practice Association Clinics regardless of insurance coverage. I agree to pay the entire balance of my account in a timely manner.

_____ _____

Responsible Party Signature Date

MPA NOTICE OF PRIVACY INFORMATION

I hereby acknowledge that I have received a copy of the Medical Practice Association's Notice of Privacy Practices

Patient Name (print): _____ Date of Birth: _____

Signature: _____ Date: _____

Relationship to Patient: _____

Patient received a copy of the MPA Notice of Privacy Practice and refused to acknowledge receipt at this time

Employee Signature: _____ Date: _____

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SOP / ASA STUDENT HISTORY FORM

NAME_____ **DOB**_____ **TODAY'S DATE**_____

Why are you here today? _____

LIST YOUR ILLNESSES, HOSPITALIZATIONS, SURGERIES, AND INJURIES:
Date Reason

_____
_____
_____

LIST YOUR CURRENT MEDICATIONS AND SUPPLEMENTS:
Name of Medicine Strength Directions for use

_____
_____
_____

ANY ALLERGIES (Medications, Food, Etc.)

_____
_____

IMMUNIZATION HISTORY:
Last Tetanus (Td or Tdap) _____ Last Influenza _____
Have you received a Pneumonia vaccine? YES NO Have you received a Shingles vaccine? YES NO

FAMILY HISTORY:
Relationship Age Any Health Problems
Father _____
Mother _____
Sibling(s) _____
Children _____

Has any blood relative ever had?:

Cancer	YES	NO	High Blood Pressure	YES	NO	Convulsions	YES	NO
Tuberculosis	YES	NO	Diabetes	YES	NO	Emotional Problems	YES	NO
Heart Trouble	YES	NO	Stroke	YES	NO	Substance Abuse	YES	NO
Gout/Arthritis	YES	NO	Bleeding Tendency	YES	NO			

SOCIAL HISTORY (Circle One):
Marital Status: SINGLE MARRIED SEPARATED DIVORCED WIDOWED
Sexual Preference: MALE FEMALE BOTH
Have you been sexually active in the last month? YES NO

How many people live in your household? _____ What form of transportation do you use? _____
Employed outside of the home? YES NO What is your job title? _____
Are you or have you ever been exposed to fumes, dusts, or solvents? YES NO

Do you use tobacco (cigarettes, cigars, pipe, chewing tobacco)? YES NO If no, previous use? YES NO
Amount used (previous or current)? _____ Packs per day
Do you use alcoholic beverages? YES NO Amount used? _____ Drinks per week _____
Have you ever used any of the following? MARIJUANA ___ COCAINE ___ HEROIN ___ METHAMPHETAMINE ___
OTHER IV DRUGS ___

SOCIAL HISTORY *Continued* (Circle One):

Seatbelts?	ALWAYS	SOMETIMES	NEVER	
Sunscreen?	ALWAYS	SOMETIMES	NEVER	
Exercise?	ALWAYS	SOMETIMES	NEVER	
Regular Balanced Meals?	ALWAYS	SOMETIMES	NEVER	
See a dentist regularly?	YES	NO	Last dentist appointment? _____	
See an eye doctor regularly?	YES	NO	Last eye exam? _____	

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Recent weight change	YES	NO	Fast or skipped heartbeat	YES	NO	Urinating more often	YES	NO
Skin disease	YES	NO	Chest pain or heaviness	YES	NO	Night time urination	YES	NO
Jaundice (yellow skin)	YES	NO	Shortness of breath	YES	NO	Burning/painful urination	YES	NO
Hives, eczema, rash	YES	NO	Heart trouble/heart attack	YES	NO	Blood in urine	YES	NO
Moles or skin changes	YES	NO	High blood pressure	YES	NO	Kidney infection	YES	NO
Eye problems	YES	NO	Swelling hands/feet/ankles	YES	NO	Kidney stones	YES	NO
Wear glasses	YES	NO	Heart murmur	YES	NO	Bladder incontinence	YES	NO
Double vision	YES	NO	Blood clots	YES	NO	Sexually transmitted disease	YES	NO
Headaches	YES	NO	Anemia	YES	NO	Convulsions/seizures	YES	NO
Nosebleeds	YES	NO	Peptic ulcer	YES	NO	Fainting spells	YES	NO
Sinus trouble	YES	NO	Vomiting	YES	NO	Shaking or trembling	YES	NO
Ear problems	YES	NO	Gallbladder disease	YES	NO	Muscle weakness	YES	NO
Hearing loss	YES	NO	Liver disease	YES	NO	Stiff or painful joints	YES	NO
Dizziness	YES	NO	Hepatitis	YES	NO	Hot or cold flashes	YES	NO
Difficulty swallowing	YES	NO	Blood in stool	YES	NO	Difficulty making decisions	YES	NO
Neck stiffness	YES	NO	Black stool	YES	NO	Memory loss	YES	NO
Thyroid disease	YES	NO	Change in bowel habits	YES	NO	Difficulty relaxing	YES	NO
Swollen glands	YES	NO	Diarrhea	YES	NO	Do you lose your temper often	YES	NO
Coughing	YES	NO	Heartburn/indigestion	YES	NO	Are you having sexual problems	YES	NO
Asthma/wheezing	YES	NO	Abdominal pain	YES	NO	Do you feel lonely or depressed	YES	NO
Problems breathing	YES	NO	Trouble sleeping	YES	NO	Have you ever considered suicide	YES	NO
Lung disease	YES	NO	Feel tired most of the time	YES	NO	Panic or anxiety attacks	YES	NO

Do you consider your health (circle one): EXCELLENT GOOD FAIR POOR

FOR MEN ONLY:

Last testicular exam _____ Last prostate exam _____

FOR WOMEN ONLY:

Age menstrual cycles began _____
How often are periods? Every_____ days
How long do periods last? _____days
How long do periods last? _____days
How long do periods last? _____days
Date of last period _____
Vaginal discharge YES NO

Last mammogram (breast exam) _____
Breast lump or nipple discharge YES NO

Last pap smear & results _____
Number of pregnancies _____
Number of miscarriages/abortions _____
Have you ever had a DEXA scan? YES NO
If so, when was your last one? _____

REVIEW:

Signature _____ Date _____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

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Audit-C Form

Please mark and "X" to indicate your answer.

Did you have a drink containing alcohol in the past year?

☐ Yes

☐ No

If "Yes": How often did you have a drink containing alcohol in the past year?

☐ never (0 point)

☐ Monthly or Less (1 point)

☐ 2 to 4 times a month (2 points)

☐ 2 to 3 times a week (3 points)

☐ 4 or more times a week (4 points)

If "Yes": how many drinks did you have on a typical day when you were drinking in the past year?

☐ 1 or 2 drinks (0 point)

☐ 3 or 4 drinks (1 point)

☐ 5 or 6 drinks (2 points)

☐ 7 to 9 drinks (3 points)

☐ 10 or more drinks (4 points)

If "Yes": How often did you have 6 or more drinks on one occasion in the past year?

☐ never (0 point)

☐ Less than monthly (1 point)

☐ Monthly (2 points)

☐ Weekly (3 points)

☐ Daily or almost daily (4 points)

Interpretation: ☐ Positive ☐ Negative

Interpretation:

The AUDIT-C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use).

- In men, a score of 4 or more is considered positive.
- In women, a score of 3 or more is considered positive.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have questions about this notice or want more information, please contact our Privacy Officer at (316) 293-2620.The effective date of this notice is May 18, 2023.

KU School of Medicine – Wichita Medical Practice Association ("MPA") collects individually identifiable information about you in the course of providing services to you. We may use and disclose your health information without your express consent or authorization for some purposes, while other purposes require us to obtain your express written authorization before using or disclosing your information. You may revoke such authorization, in writing, at any time to the extent MPA has not relied on it.

We must give you this Notice about our privacy practices and follow these practices. We may update this Notice to show any changes in our privacy practices. The new Notice will be effective for all protected health information that we maintain. We will post a copy of the current Notice in places where you receive services. You may request a copy of the revised notice by calling MPA or asking for one at the time of your next appointment.

HOW MPA MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

We may use and disclose your health information without an authorization for treatment, payment, and health care operations.

Treatment. We may use your health information to provide you with medical treatment. We may disclose information to doctors, nurses, technicians, medical students, or other personnel involved in your care. We also may disclose information to persons outside MPA involved in your treatment, such as other health care providers, family members, and friends.

Payment. We may use and disclose your health information as necessary to collect payment for services we provide to you. We also may provide information to other health care providers to assist them in obtaining payment for services they provide to you.

Health Care Operations. We may use and disclose your health information for our internal operations. These uses and disclosures are necessary for our day-to-day operations and to make sure patients receive quality care. We may disclose health information about you to another health care provider or health plan with which you also have had a relationship for purposes of that provider's or plan's internal operations.

We may disclose and use your health information and you authorize us to use and disclose your information for:

Appointment Reminders. We may provide appointment reminders to you. You may request in writing that we send reminders to a confidential or alternative address.

Treatment Alternatives. We may provide you with information about treatment alternatives and other health related benefits and services.

We may also disclose your health information to outside entities without your consent or authorization in the following circumstances:

Business Associates. MPA provides some services through contracts or arrangements with business associates. We require our business associates to appropriately safeguard your information.

Creation of de-identified health information. We may use your health information to create de-identified health information. This means that all data items that would help identify you are removed or modified.

Uses and disclosures required by law. We will use and/or disclose your health information when required by law to do so.

Disclosures for public health activities. We may disclose your health information to a government agency authorized (a) to collect data for the purpose of preventing or control disease, injury, or disability; or (b) to receive reports of child abuse or neglect. We also may disclose such information to a person who may have been exposed to a communicable disease if permitted by law.

Disclosures about victims of abuse, neglect, or domestic violence. MPA may disclose your health information to a government authority if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

Research. Your information may be used by or disclosed to researchers for research approved by a privacy board or an institutional review board.

Health Oversight Activities. Your health information may be disclosed to governmental agencies and boards for investigations, audits, licensing, and compliance purposes.

Disclosures for judicial and administrative proceedings. Your protected health information may be disclosed in response to a court order or in response to a subpoena, discovery request, or other lawful process if certain legal requirements are satisfied.

Disclosures for law enforcement purposes. We may disclose your health information to a law enforcement official as required by law or in compliance with a court order, court-ordered warrant, a subpoena, or summons issued by a judicial officer; a grand jury subpoena; or an administrative request related to a legitimate law enforcement inquiry.

Disclosures regarding victims of a crime. In response to a law enforcement official's request, we may disclose information about you with your approval. We may also disclose information in an emergency situation or if you are incapacitated if it appears you were the victim of a crime.

Deceased Individual. We may disclose information for the identification of the body or to determine the cause of death.

Military and Veterans. If you are a member of the armed forces we may release information about you as required by military command authorities. We may also release information about foreign military personnel to the appropriate foreign military authority.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official. This release must be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety or security of the correctional institution.

Disclosures to avert a serious threat to health or safety. We may disclose information to prevent or lessen a serious threat to the health and safety of a person or the public or as necessary for law enforcement authorities to identify or apprehend an individual.

Disclosures for specialized government functions. We may disclose your protected health information as required to comply with governmental requirements for national security reasons or for protection of certain government personnel or foreign dignitaries.

Organ and Tissue Donation. If you are an organ donor, we may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ bank, as necessary to facilitate organ or tissue donation.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs.

We will give you the opportunity to object to the following uses and disclosure of your information:

Notification. We may tell your friends, relatives and other caretakers information which is relevant to their involvement in your care.

Disaster Relief. We may disclose information about you to public or private agencies for disaster relief purposes.

Except as provided above, we will obtain your written authorization prior to disclosure of your information for any other purpose. Specifically, written authorization is required prior to the disclosure of your information:

Psychotherapy Notes. We will not use or disclose your psychotherapy notes without a written authorization except as specifically permitted by law.

Marketing. We will not use or disclose your information for marketing purposes, other than face-to-face communications with you or promotional gifts of nominal value, without your written authorization.

Sale of Information. We will not sell your Protected Health Information without your written authorization, including notification of the payment we will receive.

Where a disclosure is made under your written authorization, you have the right to revoke the authorization at any time. Revocation of an authorization must be in writing. The revocation is effective as of the date you provide it to us and does not affect any prior disclosures made under the authorization.

If a state or federal law provides additional restrictions or protections to your information, we will comply with the most stringent requirement.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

Right to Inspect and Copy. You have the right to inspect and copy health information maintained by MPA. To do so, you must complete a specific form providing information needed to process your request. If you request copies, we may charge a reasonable fee. We may deny you access in certain limited circumstances. If we deny access, you may request review of that decision by a third party, and we will comply with the outcome of the review.

Right To Request Amendment. If you believe your records contain inaccurate or incomplete information, you may ask us to amend the information. To request an amendment, you must complete a specific form providing information we need to process your request, including the reason that supports your request.

Right to an Accounting of Disclosures. You have the right to request a list of disclosures of your health information we have made, with certain exceptions defined by law. To request this list, you must complete a specific form providing information we need to process your request.

Right to Request Restrictions. You have the right to request a restriction on our uses and disclosures of your health information for treatment, payment, or health care operations. You must complete a specific form providing information we need to process your request. We are required to agree to a request for a restriction related to disclosure of information to your health plan for payment or healthcare operations where you pay for the service in full. We are not otherwise required to agree to any restriction on the use or disclosure of your information. MPA's Privacy Officer is the only person who has the authority to approve such a request.

Right to Request Alternative Methods of Communication. You have the right to request that we communicate with you in a certain way or at a certain location. You must complete a specific form providing information needed to process your request. MPA's Privacy Officer is the only person who has the authority to act on such a request. We will not ask you the reason for your request, and we will accommodate all reasonable requests.

Notice of Privacy Practices. You have the right to request a paper copy of this Notice.

OUR DUTIES.

We are required by law to maintain the privacy of Protected Health Information and to provide individuals with this Notice of our legal duties and privacy practice regarding health information.

We are required to notify you if there is a breach of your unsecured Protected Health Information.

We are required to follow the terms of the current Notice.

We may change the terms of this Notice and the revised Notice will apply to all health information in our possession. If we revise this Notice, a copy of the revised Notice will be posted and a copy may be requested from our Privacy Officer at the number listed at the beginning of this form.

COMPLAINTS.

If you believe your rights with respect to health information have been violated, you may file a complaint with MPA or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with MPA, **please contact Privacy Officer, KU School of Medicine – Wichita Medical Practice Association, 1010 N. Kansas, Wichita, Kansas 67214 or at (316) 293-2620**. We request complaints be submitted in writing. **You will not be penalized for filing a complaint**.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to:

U.S. Department of Health and Human Services Office for Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

Or by calling: 1-877-696-6775
Or visit: https://www.hhs.gov/hipaa/filing-a-complaint/

We will not retaliate against you for filing a complaint.

YOUR RIGHTS REGARDING ELECTRONIC HEALTH INFORMATION EXCHANGE.

KU School of Medicine – Wichita Medical Practice Association (MPA) participates in the electronic exchange of health information with other healthcare providers and health plans through an approved health information organization (HIO). Through our participation, your PHI may be accessed by other providers and health plans for the purposes of treatment, payment, or health care operations. MPA may use other providers' information in the coordination of care. The approved HIO is required to maintain safeguards to protect the privacy and security of PHI. The approved HIO may only allow authorized personnel to access PHI through the HIO.

Under Kansas law, you have the right to decide whether providers and health plans can access your health information through an HIO. You have two choices. First, you can permit authorized individuals to access your PHI maintained through an HIO for treatment, payment, or health care operations. If you choose this option, you do not have to do anything.

Second, you can restrict access to your PHI maintained through an HIO. To do so you must submit a request to opt out of HIE through the Kansas Health Information Technology by visiting www.kanhit.org or calling KanHIT at (785) 296-8627 for more information. You can restrict KU School of Medicine – Wichita Medical Practice Association from making your PHI available to the HIO by following instructions at the section above, "Right to Request Restrictions". Even if you restrict access through (or opt out of participating in) an HIO, providers and health plans may share your information through already available other legal means without your specific authorization.

Please understand your decision to restrict access to your electronic health information through an HIO may limit your health care providers' ability to provide the most effective care for you. By submitting a request for restrictions, you accept the risks associated with that decision.

END