KU WICHITA PSYCHIATRY & BEHAVIORAL SCIENCES
The University of Kansas

DATE: _____

PATIENT: _____

FROM: KU Adult and Geriatric Psychiatry Clinic

PROVIDER: _____

LOCATION: 1001 N. Minneapolis, Wichita, Kansas PATIENT ENTRANCE

APPOINTMENT DATE AND TIME: _____

You currently have an appointment scheduled with us as indicated above. We look forward to providing you with the best possible care. In order for us to achieve this goal, we need you to complete the enclosed registration forms and bring them with you to initial appointment.

If your paperwork is not complete or you forget to bring it with you, your appointment may need to be rescheduled.

Plan to be here approximately one hour for the initial evaluation. **Please arrive 15 minutes early for your first appointment to complete any additional forms.** If you are late, your appointment may need to be rescheduled and you may have to wait several weeks.

ALSO BRING TO YOUR APPOINTMENT:

- Insurance cards
- A complete list of ALL current and previous medications, including dosage
- List of physicians you are currently receiving treatment from. (Please include phone numbers and addresses).
- Legal Documents such as: Durable Power of Attorney and/or Guardianship

If you have any questions or need further information, you may call the office at 316-293-2647. You may leave a message at any time.

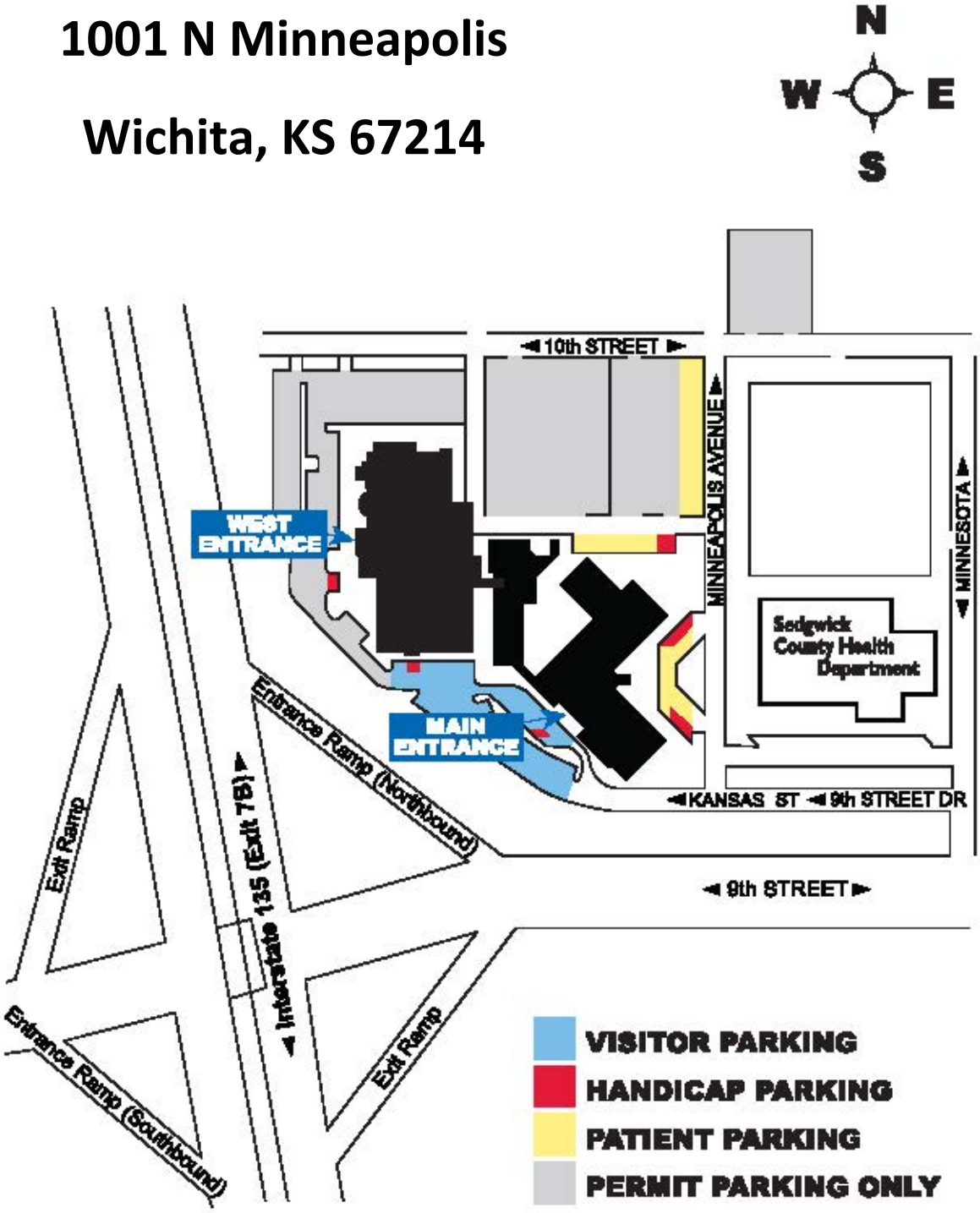
To reschedule or cancel your appointment(s) please call the clinic at least 24 hours before your appointment if you need to cancel or reschedule. Three (3) missed appointments within 12 months, inclusive of cancelations less than 24 hours in advance**,** may result in dismissal from practice**.**

Thank you.

KU WICHITA PSYCHIATRY & BEHAVIORAL SCIENCES
The University of Kansas

1001 N Minneapolis

Wichita, KS 67214



1001 N. Minneapolis | Wichita, KS 67214-3127 | P . (316) 293-2647 | F. (855) 476-0305

KU WICHITA PSYCHIATRY & BEHAVIORAL SCIENCES
The University of Kansas

PATIENT INFORMATION

Social Security Number:	Employer:
Name:	Employer Address:
Address:	Employer City:
City:	Employer State: Zip:
State: Zip:	Email:
Home Phone Number:	Referring Provider:
Work Phone Number:	Primary Care Provider:
Cell Phone Number:	Marital Status:
Sex:	Employment: FT / PT / Self / Military / Unemployed / Retired
Date of Birth:	Student Status: FT / PT / Not a student
Race: American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or Other Pacific Islander / White / Declined	Preferred Language:
Ethnicity: Hispanic or Latino / Refused / Not Hispanic or Latino	Preferred Hospital:

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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KU SCHOOL OF MEDICINE - WICHITA MEDICAL PRACTICE ASSOCIATION
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 June 7, 2013.

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 plans 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 or 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 Restriction. 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 operation where you pay for the service in full. We are not otherwise required to agree to any other restriction 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.**

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 in the State of Kansas 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 Exchange, Inc. by visiting www.khie.org or calling the KHIE Support Center at (785) 783-8984 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.

KU WICHITA PSYCHIATRY & BEHAVIORAL SCIENCES
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PATIENT HISTORY QUESTIONNAIRE

Please complete this questionnaire and give it to your physician or therapist at your first appointment. This information will help your clinician gain an understanding of the problems for which you are seeking help with and other important events in your life.

Your Full Name	Date of Birth	Age
Who Referred you to this clinic?	Today's Date	

What Emotional, Behavioral or Interpersonal Problems Are You Experiencing?

How Long Have These Problems Been Affecting Your Life?

PREVIOUS TREATMENT

Have You Received Previous Treatment For Mental Health Problems?

( ) No ( ) Yes (describe below)

DATE	NAME OF FACILITY OF PROFESSIONAL WHO PROVIDED TREATMENT	TYPES OF TREATMENT (Medication,Psychotherapy, Hospitalization, etc.)	RESPONSE

Have You Ever Attempted Suicide? ( ) Yes ( ) No

Do You Consider Yourself A High Risk To Attempt Suicide In The Near Future? ( ) Yes ( ) No

Have You Considered Yourself Or Any Family Member A Serious Threat To Do Harm Or Be Harmed By Someone?

( ) Yes ( ) No

If Yes, Describe

LIST ANY MEDICATIONS YOU ARE TAKING **AT THIS TIME**		
Name of Medication	When Taken	How Much (Dose)

List Any Medications That Have Caused You to Experience Severe Side Effects (But Not Allergic Reactions)

List Any Medications That Have Caused Allergic Reactions (For Example: Rash, Itching, Shortness of Breath)

SUBSTANCE ABUSE

Describe Your Use Of The Following Substances	Age When First Used	Previous Use		Current Use	
		Frequency	Quantity	Frequency	Quantity
Caffeine					
Cigarettes/Other Nicotine					
Alcohol					
Cannabinoids (marijuana, pot)					
Stimulants (amphetamines, speed, crank)					
Depressants (barbiturates, downers, barb)					
Opiates (methadone, heroin, codeine, morphine)					
Hallucinogen(PCP, LSD, mescaline, acid)					
Combinations (creep)					
Others (inhalants, "huffing" paints, gasoline)					

	Yes	No
Do you sometimes use more than you planned of one of the previous substances?		
Do you find yourself frequently thinking about or preoccupied with one of these substances?		
Has a family member or friend ever expressed concern about your alcohol/drug use?		
Have You ever missed school or work because of intoxication or a hangover?		
Have you ever tried to stop using drugs or alcohol without success?		
Have you ever experienced legal problems (arrests, DUIs) for your behavior while under the influence of alcohol or drugs?		
Have you ever been under treatment for alcohol or substances abuse problems?		

DEVELOPMENTAL HISTORY

Describe, If Known, Any Difficulties Your Mother May Have Had During Her Pregnancy, Labor or Delivery With You.

_____

Indicate Any Problems Experienced During Childhood/Adolescence	Yes	No	As a child or adolescent, did you experience any of the following?	
Delayed speech			Physical abuse	Describe
Delayed motor development				
Excessive shyness			( ) No ( ) Yes	
Excessive aggression			Sexual abuse	Describe
Hyperactivity				
Learning problems			( ) No ( ) Yes	
Poor peer relationships			Loss of a parent	Describe
Drug abuse				
Excessive alcohol consumption			( ) No ( ) Yes	
Depression			Other trauma	Describe
School failure/dropout				
Runaway behavior			( ) No ( ) Yes	
Illegal behavior			Do you think these past experiences of loss and trauma are influencing the problems that bring you to treatment? ( ) Yes ( ) No	

EDUCATION AND EMPLOYMENT

List Any Recent Changes	Describe Plans You Have To Make Changes

Education Years of Education Completed — Highest Degree Earned (include GED)
Field of Study — Technical or Trade School

Current Occupation

Employment

Have you ever been employed outside the home Yes ( ) No ( )

What was the longest job held and for how long? _____

If not currently employed, when was the last time you were employed and what did you do? _____

Military Service	Branch	Highest Rank	Type of Discharge
( ) No ( ) Yes			

MEDICAL HISTORY

	Yes	No
Any unusual childhood illness: If so, what were they?		
Any serious medical illnesses as an adult: If so, what were they?		
Any surgeries: If so, what were they and when?		
Have you ever been in a major accident?		
Have you ever had a loss of consciousness?		
Have you ever had a seizure?		

If Female: Reproductive History

Number of pregnancies _____
Number of live births _____
Date of last menstrual period _____
Form of birth regulation
Birth control pills _____
Foam _____
Diaphragm _____
Tubal Ligation _____
Hysterectomy _____

REVIEW OF SYSTEMS

Check whether you have any of the following as a recurrent and significant problem

Complaint	Yes	No	Comment if desired
Headaches			
Joint aches			
Muscle aches			
Dizzy spells			
Fainting			
Vision difficulties			
Breathing difficulties			
Heart irregularities			
Heart burn			
Bloating			
Food intolerance			
Diarrhea			
Constipation			
Abdominal cramps			
Premenstrual tension			
Menstrual problems			
Bladder problems			
Skin problems			
Seizures			
Weight gain			
Weight loss			

FAMILY HISTORY

Born and raised – Where:

Where Were You In Birth Rank Order:

Raised in an intact family of origin: ( ) Yes ( ) No If not, please describe

What Was It Like To Grow Up In Your Family? Describe Any Significant Events That You Think Might Be Important In Understanding Or Solving The Problems That You Bring To Treatment

List any family members (mother, father, brother, sister, spouse, son, daughter) that have been treated for mental disorders such as schizophrenia, depression, manic depression, alcohol/drug addiction, attention deficit disorder or severe anxiety disorder and indicate the types of treatment they received (for example: psychotherapy, medication, hospitalization)

FAMILY MEMBER	DISORDER	TYPE OF TREATMENT

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CLINIC POLICIES

CONFIDENTIALITY: All communication between you and the clinic is held in strictest confidence and will not be released unless: (1) you authorize release of information with your signature; (2) you present with potential harm to yourself or others; (3) there is suspicion of abuse or neglect of a minor or elder; or (4) the clinic is required to do so by federal, state, or local law. _____ (INITIAL)

EMERGENCIES: In case of emergency, **call 9-1-1** or **go to your nearest emergency room.** For emergencies occurring after business hours, you may call the Via Christi operator at (316) 268-5000. For non-emergent calls you may call the office at (316) 293-2647 and leave a message. Your phone call will be returned the next business day. _____ (INITIAL)

INSURANCE, CO-PAYS, DEDUCTIBLES AND BALANCES: Payment in full is due at the time services are rendered. This includes co-pays, deductibles, balances and charges not covered by your insurance company. We file insurance claims for you as a courtesy. Any claim denied due to patient ineligibility, benefit limits, or services not covered will be billed directly to the patient. _____ (INITIAL)

COLLECTIONS: After 90 days, unpaid accounts will be sent to a collection agency which **may result in dismissal from practice**. _____ (INITIAL)

APPOINTMENTS: Please call the clinic at least 24 hours before your appointment if you need to cancel or reschedule. Three (3) missed appointments within 12 months, inclusive of cancelations less than 24 hours in advance**, may result in dismissal from practice**. _____ (INITIAL)

FORM COMPLETION: $25.00. Fee will be charged and must be paid by the patient prior to provider completing forms. (This does not include KU School of Medicine-Wichita new patient forms.) _____ (INITIAL)

RX HISTORY: I understand and give consent for the clinic to access my prescription medication history from other providers and/or pharmacies. _____ (INITIAL)

INCLEMENT WEATHER: In the event of severe weather, please call the clinic before you come. A recording will alert you if the clinic is closed. We will call you the next open day to reschedule your appointment. _____ (INITIAL)

TRAINEES: UKSM-Wichita is a teaching clinic, therefore psychology interns or fellows, medical students, or resident physicians may be a part of your treatment, supervised by your provider. _____ (INITIAL)

RESEARCH: UKSM-Wichita also works with physicians who are performing a variety of research projects. Your physician or a member of the research team may discuss these projects as viable alternatives or additions to your regular care. You may be asked to participate in this research, but you are under no obligation to do so. _____ (INITIAL)

CONTACT WITH THE CLINIC: Failure to maintain contact with the clinic for longer than a 12 month period, without the consent of your provider, will automatically change your status to inactive. Should you wish to return to the clinic, you will need to repeat the intake process. _____ (INITIAL)

I have read, initialed, and fully understand and accept responsibility for each item described above.

_____	_____	_____
(Patient Printed Name)	(Patient/Guardian Signature)	(Date)

Revised 8/1/2016

KU WICHITA PSYCHIATRY & BEHAVIORAL SCIENCES
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CONSENT FOR OUTPATIENT TREATMENT

This document is to obtain your informed consent for evaluation and treatment. Please ask your provider for clarification if you do not fully understand the recommendations.

I hereby consent to a psychiatric evaluation and subsequent treatment, subject to my ongoing involvement in providing consent. I understand that if I wish to accept treatment, I have the right to have the risks and benefits of treatment options explained to me to my satisfaction, including not having any treatment. I understand that I may at any time refuse any intervention in which I do not wish to participate.

_____	_____	_____
Printed Name of Patient	Signature of Patient	Date
_____	_____	_____
Printed Name of Parent or Representative	Signature of Parent or Representative	Date
_____	_____	_____
Printed Name of Clinic Representative	Signature of Clinic Representative	Date

FOR CHILDREN and ADOLESCENTS

Are there custody arrangements, either current or pending, between any parties?

☐ Yes ☐ No

If Yes, please provide additional details: _____

_____

Do any of the following apply to this child/adolescent?

Legal Guardian	☐ No	☐ Yes, Name: _____	Ph: _____
SRS Involvement	☐ No	☐ Yes, Name: _____	Ph: _____
Juvenile Justice Involvement	☐ No	☐ Yes, Name: _____	Ph: _____

PLEASE PROVIDE COPIES OF ANY COURT ORDERS

OR OTHER LEGAL DOCUMENTATION

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DEFINTIONS

Allowable: The discounted fee for service a healthcare provider has contractually agreed to accept from an insurance company. It is listed by CPT code in a fee schedule available from your insurance company.

Coinsurance: A cost-sharing requirement of some insurance plans where the patient assumes a percentage of the costs for covered services after the amount of the deductible has been met. Coinsurance is described as a ratio, for example 30/70, meaning the patient is responsible for paying 30% and the insurance will pay 70% of the allowable.

Copayment (co-pay): The amount to be paid to a physician by, or on behalf of, the patient in connection with the services rendered by the physician. It is due at the time of service, is a fixed amount determined by the insurance company based on the level of benefit, and is usually found printed on the patient's insurance card.

CPT code: Current Procedural Terminology codes maintained by the American Medical Association. These five digit codes describe most medical, surgical, and diagnostic services and are used for administrative, financial, and analytical purposes.

Deductible: The amount paid by the member before insurance will begin to reimburse services. It is reset annually, and based on the level of benefits or amount of premium paid. For example, with a $1,000 deductible the patient must pay medical providers for the first $1,000 of allowable expenses incurred by the patient each year, after which costs may be split according to a coinsurance arrangement, and/or may be limited to the patient's out of pocket expenses.

Explanation of Benefits (EOB): The insurance company's explanation of the benefits they have, or have not, paid to a provider along with any remaining amounts for which the patient is responsible, if any.

Health Maintenance Organization (HMO): a type of health Insurance program in which patients receive benefits when they obtain services that are provided, or authorized by, selected providers. HMO members generally need a written referral from their primary care physician to see a hand specialist.

ICD code: The International Statistical Classification of Diseases and Related Health Problems provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease. Every health condition can be assigned to a unique category and given a code, up to six characters long.

Insurance Verification: the process where a healthcare provider contacts the financially responsible party (usually an insurance company, Medicare, or an employer) and verifies that coverage is in effect and the information current. This generally includes the amount of the deductible met by the patient, copayment amounts, and coinsurance terms.

Medicaid: The United States health program for eligible individuals and families with low incomes and resources. It is a means-tested program that is jointly funded by the states and federal government, and is managed by the states.

Medicare: a social insurance program funded by taxes and administered by vendors hired by the United States government. Medicare provides health insurance coverage to people who are aged 65 and over, or who meet other special criteria.

Out of pocket expense: The total of covered health care expenses that are paid for by the member or patient, not including any premium. This is typically the total of the deductible and any coinsurance paid during a year.

Precertification: The process of obtaining approval from insurance, in advance, for a proposed treatment or diagnostic test.

Preferred Provider Organization (PPO): A type of health insurance program in which enrollees receive a higher level of benefits when they select from a list of "preferred providers" that have contracted with the insurance company at a discount.

Premium: The monthly amount enrollees pay the insurance company to be covered.