MICHAEL L. LACCHEO, M.D., P.A.
FELLOW, AMERICAN ACADEMY OF FAMILY PHYSICIANS
The Jos. Warren Building
1119 SW Gage Boulevard, Topeka, KS 66604
(785) 271-6000

PATIENT INFORMATION

PLEASE PRINT

Name _____
First Middle Name Last

Address _____
Street City State Zipcode

_____

☐M ☐F _____ ☐S ☐M ☐W ☐D _____ _____
Sex **Date of Birth** **Marital Status** **HomePhone** **Cell Phone**

Occupation _____ **Employer** _____ **Work Phone** _____

Spouse _____
First Middle Last Date of Birth Cell Phone

_____
PRIMARY INSURANCE Policy# or ID # Group # Policyholder

_____
SECONDARY INSURANCE Policy# or ID # Group # Policyholder

Friend/Relative NOT living with you _____ _____
Emergency Phone Contact

******BY SIGNING BELOW, I UNDERSTAND THAT AFTER MY INSURANCE COMPANY PAYS ACCORDING TO THE CONTRACT OF MY POLICY, I AM FULLY RESPONSIBLE FOR PAYMENT OF THE REMAINING ACCOUNT BALANCE IN A TIMELY FASHION.******

SIGNATURE _____ Date _____/_____/_____

SIGNATURE _____ Date _____/_____/_____

SIGNATURE _____ Date _____/_____/_____

SIGNATURE _____ Date _____/_____/_____

SIGNATURE _____ Date _____/_____/_____

I HEREBY AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION RECORD TO:

_____
NAME OF PERSON(S)

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.
Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.
Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules.
Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment.

_____ _____
Signature of Patient or Legal Representative Date