



DIPLOMATS AMERICAN BOARD OF FAMILY PRACTICE
KIMBERLEY MCKEON M.D.
JOY R. MURPHY M.D.
BRAD PHIPPS M.D.
CARLA BROWN PHIPPS M.D.
STEVEN THOMSEN M.D.

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY

POLICY/MEMBER ID# GROUP/ACCOUNT#

SUBSCRIBER NAME SS#

SUB BIRTH DATE RELATION TO PT

SECONDARY INSURANCE COMPANY

POLICY/MEMBER ID# GROUP/ACCOUNT#

SUBSCRIBER NAME SS#

SUB BIRTH DATE RELATION TO PT

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). Our practice may use and disclose your IIHI in order to bill and collect payment for services received from us. We may also contact your health insurer to certify eligibility or for benefit coverage. We may provide your insurer with details regarding your treatment to determine payment for your treatment. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

I understand I must present my insurance card at every office visit and that I will be responsible for my co-pay at the time of service. Also, I understand I will be billed for any deductible or co-ins designated by my insurance provider. If I provide incorrect or out of date insurance information I may also be responsible for those services.

PATIENT NAME DATE

PATIENT SIGNATURE (or responsible party)

SELF-PAY PATIENTS

I understand as a patient without current insurance coverage that I will be responsible for services I receive. I also understand that payment is due in full at the time of service. If payment in full cannot be made at the time of service, I agree to make payment arrangements with the billing office before services are rendered. Additionally, if payment in full is made at the time of service, a 10% adjustment will be given.

PATIENT NAME DATE

PATIENT SIGNATURE (or responsible party)

Telephone: (785) 841-6540 • Billing and Mailing: 4951 W. 18th Street, Lawrence, KS 66047 • Fax: (785) 841-3129
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