

INTERNAL MEDICINE
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PLEASE COMPLETE THE ENTIRE FORM AND SIGN

Child's Name _____ Sex _____ Birthdate _____ SS# _____
Mother's Name _____ Marital Status _____ Birthdate _____ SS# _____
Father's Name _____ Marital Status _____ Birthdate _____ SS# _____
Home Address _____ Phone # _____
City _____ State _____ Zip Code _____
Billing Address (if different) _____
Father's Employer _____ Address _____ Phone # _____
Mother's Employer _____ Address _____ Phone # _____

PRIMARY INSURANCE INFORMATION

Carrier Name _____ Address _____
Cardholder Name _____ SS# _____ Birthdate _____
Cardholder Address _____ Phone # _____
Cardholder Employer _____ Address _____ Phone # _____
Patients Relationship to Cardholder Self Spouse Dependent Other (explain) _____
Policy Number _____ Group # _____

SECONDARY INSURANCE INFORMATION

Carrier Name _____ Address _____
Cardholder Name _____ SS# _____ Birthdate _____
Cardholder Address _____ Phone # _____
Cardholder Employer _____ Address _____ Phone # _____
Patients Relationship to Cardholder Self Spouse Dependent Other (explain) _____
Policy Number _____ Group # _____
Name of Person Responsible for account? _____ Relationship to Patient _____

TREATMENT AUTHORIZATION & STATEMENT OF FINANCIAL RESPONSIBILITY

I hereby authorize the physicians of Lee's Summit Physicians Group, Inc. to provide medical care to the individual(s) listed above which involves, but is not limited to, evaluation and management services, laboratory testing, x-rays, breathing treatments, immunizations and injections as recommended by the physician and other such services necessary in the provision of quality medical care. I understand that I am financially responsible for all charges and that insurance payments are between the insured and insurance company. I authorize the release of any information to my insurance company necessary to facilitate the payment of insurance claims.

Signed: _____ Date _____
Signed: _____ Date _____
Signed: _____ Date _____
Signed: _____ Date _____