Thank you for selecting

EAST LINCOLN FAMILY HEALTH PROF., P.C./NEBRASKA COMPREHENSIVE HEALTH CARE/ NEBRASKA MENTAL HEALTH CENTERS

We will strive to provide you with the best possible care. To help us meet your entire healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask and we will be happy to help.

DATE ____/____/____

Patient/Guarantor Information

Check Appropriate Box ❑Minor ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Name (Last, First, Middle Initial) _____ ❑Male ❑Female

DOB _____ Soc Sec # ____-____-____ Race _____ Religion_____

Home Phone ____-____-____ Work Phone ____-____-____ Cell Phone____-____-____

Address_____ City _____ ST _____ Zip _____

Email _____ Referred By: _____

Emergency Contact _____ Relationship _____ Phone ____-____-____

Non Family Member Emergency Contact _____ Relationship _____ Phone ____-____-____

Student ❑Yes ❑No ❑Part-time ❑Full-time Name of School/College _____

Employed ❑Yes ❑No ❑Retired ❑Part-time ❑Full-time Job Description_____

Employer_____ Work Phone ____-____-____

Employer's Address _____ City _____ ST _____ Zip _____

Other Responsible Party's Information

Check Appropriate Box ❑Minor ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Name (Last, First, Middle Initial) _____ ❑Male ❑Female

DOB _____ Soc Sec # ____-____-____ Race _____ Religion_____

Home Phone ____-____-____ Work Phone ____-____-____ Cell Phone____-____-____

Address_____ City _____ ST _____ Zip _____

Email _____ Student ❑Yes ❑No -- ❑Part-time ❑Full-time

Employed ❑Yes ❑No ❑Retired ❑Part-time ❑Full-time Job Description_____

Employer_____ Work Phone ____-____-____

Employer's Address _____ City _____ ST _____ Zip _____

-over-

Insurance Information

Primary Insurance Company _____ Phone ____-____-____

Address_____ City _____ ST _____ Zip _____

Policy # _____ Group #_____ Effective Date ____/____/____

Policy Holder's Name _____ Policy Holder's Phone ____-____-____

Policy Holder's Address _____ City _____ ST _____ Zip _____

Policy Holder's Soc Sec # ____-____-____ DOB _____ Relationship to Patient _____

Insurance thru Employer ❑Yes ❑No Employer_____ Work Phone ____-____-____

Employer's Address _____ City _____ ST _____ Zip _____

Secondary Insurance ❑Yes ❑No

Secondary Insurance Company _____ Phone ____-____-____

Address_____ City _____ ST _____ Zip _____

Policy # _____ Group #_____ Effective Date ____/____/____

Policy Holder's Name _____ Policy Holder's Phone ____-____-____

Policy Holder's Address _____ City _____ ST _____ Zip _____

Policy Holder's Soc Sec # ____-____-____ DOB _____ Relationship to Patient _____

Insurance thru Employer ❑Yes ❑No Employer_____ Work Phone ____-____-____

Employer's Address _____ City _____ ST _____ Zip _____

Teritary Insurance ❑Yes ❑No

Authorization and Release

I certify that I have completed the above information to the best of my knowledge. I authorize the release of any medical information rendered to me or my child in order to process claims. I authorize and request my insurance company(s) direct payment to physicians' office or supplier of the services provided. I understand that my insurance carrier may pay less than the actual billed amount. I understand I am responsible for all copays, deductibles, co-insurances, and balances.

X _____ *Date* ____/____/____

Signature of Patient (or Parent if a Minor)

This form needs to be filled out <u>completely</u> in order for our services to be provided.

Nebraska Comprehensive Health Care
4545 South 86th
Lincoln, Nebraska 68526
402-483-6990 Phone Number
402-483-7045 Fax Number

Pharmacy Information

Patients Name _____

Pharmacy Name _____

Pharmacy Address _____

Phone Number _____

Fax Number _____

Consent for Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by the above entity for the purpose of diagnosing or providing treatment to me obtain payment for my health care bills, or to conduct health care operations of the above entity I understand that diagnosis or treatment of me by the above entity may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. The above entity is not required to agree to the restrictions that I request. However, if the above entity agrees to a restriction that I request, the restriction is binding on the above entity.

I have the right to revoke this consent in writing, at any time, except to the extent that the above entity has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my health care provider, a health care professional, a health plan, my employer, or a healthcare clearinghouse. This protected health information related to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the above entity Notice of Privacy Practices and the Patients Services and Rights Agreement prior to signing this document. A copy of the the above entity Notice of Privacy Practices and the Patients Services and Rights Agreement is available upon request. A copy of the afore-mentioned documents will also be provided to me upon my request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performance of healthcare operation of the above entity.

the above entity reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revise Notice of Privacy Practices by calling the office a requesting a revised copy to be sent by mail or asking or a copy at the time of my next appointment.

Date:_____

Patient Name:_____ Date of Birth:_____

Patient Signature:_____

Parent/Legal Guardian Signature:_____

East Lincoln Family Health/Nebraska Comprehensive Health Care/ Nebraska Mental Health Centers

OFFICE POLICY

Dear Patients,

We consider it a privileged responsibility to be chosen as your health care providers. This is a trust that does not come easily, and we will make every effort to ensure that your trust is well placed and your confidentiality be protected. To that end, we agree:

- To provide you with the best care we can, in a timely and cost effective manner with every effort to minimize waiting time.
- To return your calls as quickly as possible, and to take adequate time to understand your specific problems and when necessary, arrange for all referrals to specialists and testing facilities.
- To bill your insurance company in a timely and as accurate as possible with our billing procedures and to efficiently answer any billing questions you may have.
- To be responsive to your constructive criticism in an attempt to continuously improve our services.

In return, we ask of our patients the following that will allow us to meet the above goals:

- Current insurance cards must be shown at every visit.
- Copays must be paid at every visit. We do not bill for copays.
- Your Account balance past 30 days must be paid prior to the visit. If you cannot pay, other options may be evaluated.
- Interest of 1.8% will be charged on unpaid balances over 30 days.
- Self-Pay patients are required to pay for their visit in full at the time of service.
- If your account balance remains past due after 90 days, we will notify you that with a response from you; we may use a collection agency or our attorneys to obtain payment in full
- Please inform the front office of any change of personal information. For example: phone number, address, marital status, etc.
- Please keep all appointments. Failure to show for appointments may result in termination of your care.
- Additionally, after two "No show" or "Late Cancel" appointments, patients will be required to schedule "As Available" appointments. To avoid this inconvenience and to ensure the greatest likelihood for therapeutic success, please ensure you are available for all scheduled appointments.
- Please keep your discussion confined to the one problem for which you made the appointment. This will help us stay on schedule and allow the very best evaluation in the time provided.

Often we are asked to provide services not reimbursed by insurance and above and beyond what is a reasonable extension of a service provided for a medical condition. Under those circumstances, a reasonable charge may be added to your account about which you will be notified. These services might include writing a letter, FMLA form completions, insurance forms, disability forms, or sending a fax at your request.

Thank you for the opportunity to serve you.

Yours truly,

East Lincoln Family Health/Nebraska Comprehensive Health Care/ Nebraska Mental Health Centers

I agree to abide by the policies of the office and understand that if I do not, I maybe asked to seek care elsewhere.

Patient's Signature:_____ Date:_____

Patient's Name:_____ DOB: _____