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4525 S 86th St, Ste. B Lincoln, NE 68526
Phone: 402-483-7507
Fax: 402-483-6899
www.eastlincolnhealth.com

New Patient Paperwork Packet

Welcome to our practice!

East Lincoln Family Health Professionals, PC wants to thank you for allowing us to serve in your medical needs. We consider it a privileged responsibility to be chosen as your healthcare provider.

Please complete the following forms included in this packet in their entirety and bring them with you to your first appointment. If time allows, you may return them in the mail, or drop them off prior to your appointment.

- Practice Policies
- Demographics
- Patient Portal Consent
- Text/Email Consent
- ROI (Family/Friend)
- ROI (Healthcare Facility)
- Health History

We ask that you arrive at ____________________ for your scheduled appointment to allow you adequate time to complete the forms and it provides us time to go over your paperwork and gather all your insurance information. Please bring both your insurance card(s) and Driver's License (or photo ID) with you, as we need them to properly bill your insurance and ensure your identity. We also ask that you bring a current medication list and your immunization records, if you have them.

We thank you for choosing East Lincoln Family Health Professionals, PC (ELFHP).

E · L · F · H · P
east lincoln family health professionals, pc

Authorization to Release Information to Family/Friend/Other

Patient Name: ____ Date of Birth: __________________

Name of Person: ____

Relationship: ______________________ *Contact Number:* ________________________

Name of Person: ____

Relationship: ______________________ *Contact Number:* ________________________

Name of Person: ____

Relationship: ______________________ *Contact Number:* ________________________

☐ Check mark if Power of Attorney paperwork on file

I give my permission for East Lincoln Family Health Professionals, P.C. to exchange/release my protected health information upon request of named above. Including, but not limited to, diagnosis, treatment, appointments, results, medications, billing (unless specified otherwise):

____

____

____

This Authorization will be effective until revoked. You may revoke authorization anytime by notifying in writing to our office.

____ ____________________

Signature of Patient/Legal Guardian *Date*

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Phone: 402-483-7507
Fax: 402-483-6899

Authorization to Request and/or Release Protected Health Information

Patient Name: ___________________________________ Date of Birth: _____/_____/_______

Parent/Legal Guardian Name (if applicable): ____

For the **purpose of:** mark ALL applicable

- ☐ Transferring Medical Care
- ☐ Specialist/Continuity of Care
- ☐ Workman's Compensation/3rd Party Claim
- ☐ Disability/Life Insurance
- ☐ Other: ________________________

The specific information to be **released/exchanged** is: mark ALL that apply

- ☐ **ALL** available information- COMPLETE Medical Record
- ☐ Immunization Records
- ☐ Medical Records generated from the following dates: ______________________________
- ☐ Drug substance abuse- a separate authorization is required for federally assisted substance treatment programs.
- ☐ Mental Health/Physiological information
- ☐ Other: ________________________

I understand that the information disclosed according to this authorization may be re-disclosed by the recipient of the information and may no longer be protected by federal law. Federal law prohibits redisclosure of records from federally assisted substance abuse programs without the written consent of the patient.

Information disclosed may contain information about alcohol/drug use, mental/behavior health, sexually transmitted diseases, AIDS, HIV, or self-paid services.

I have the right to revoke this authorization at any time, by notifying ELFHP in letter or a completed Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that my provider took prior to my revocation letter/form was received. My provider cannot rescind disclosures that have already been made and may use my health information as necessary to bill and collect for services rendered.

The statements made in this authorization are binding. I understand that they take precedence over statements made in Privacy Practices. A faxed copy of this authorization shall be considered valid as the original.

*Please check mark **ONE** box following:* ☐ FROM ☐ TO:

East Lincoln Family Health Profs, PC- 4525 S 86th St, STE B, Lincoln NE 68526
Phone: 402-483-7507 Fax: 402-483-6899

From/To: Facility/Provider: ____

Address: ____

Phone: ______________________________ Fax: ______________________________

____ ____________________________________

Signature of Patient/Legal Guardian/Medial POA *Date*

ELFHP-Demographics

Name: ____
Last First Middle

Maiden Name (if applicable): ___________________________________

Preferred Name (if different than legal name): _____________________ Gender: _____________

DOB: ______ / ______ / _________

SSN: ___________–_________–___________ Marital Status: __________________

Race: _____________________ Ethnic Group: Hispanic Non-Hispanic Decline

Address: ____ Address 2: _____________________

City: _____________________ State: ________ Zip: ____________

Home Phone: ______________________ Cell Phone: ______________________

Email: _____________________________________

Employer Name: _________________________ Status: Full-time Part-time Retired N/A

**** All information is required to be provided and completed in full.***

Contacts:

Legal Guardian (please circle): Self Other: _________________________

☐ POA/Legal Guardian Paperwork on file

Guarantor Information (who is responsible for invoices/statement- can be different than policy holder)

Name: _____________________________________ Relationship: _________________________
Last First

Phone Number: ____________________________

Emergency Contact (will not have access to your medical information)

Name: _____________________________________ Relationship: _________________________
Last First

Phone Number: ____________________________

Insurance Information:

Insurance Name: ____________________________ Employer (if commercial): ____________________

Policy Holder Name: ___________________________ Relationship to Patient: __________________

Policy Holder SSN: ________–_______–________ DOB: ______/______/___________

Insurance Name: ____________________________ Employer (if commercial): ____________________

Policy Holder Name: __________________________ Relationship to Patient: __________________

Policy Holder SSN: ________–_______–________ DOB: ______/______/___________

Preferences:

Local Pharmacy Name/Location: ____

Mail Order Pharmacy: ___________________________

Hospital: ___________________________________

Authorization:

Consent to perform/provide the following for coordination of care:

- Text/Email
- Medication history reconciliation
- Immunization history sharing
- Health information exchange
    - Allows for release of medical information, including substance abuse (drugs/alcohol), mental health, sexual health, and HIV-related information for the related providers treatment and insurance records, if necessary.

To release medical information and to pay benefits to provider:

- I certify that I have completed the above information to the best of my knowledge.
- I authorize the release of any medical information rendered by ELFHP for me or my child to process claims.
- I understand it is my responsibility to understand coverage of my insurance and am responsible for all copays, deductibles, co-insurances, and other balances on accounts(s). Remaining balances will be paid in a timely manner.
- **If the patient is a minor, permission is hereby given to ELFHP to treat the patient, without the presence of a parent or guardian.**

____ ________________________

Signature of Patient/Legal Guardian *Date*

HEALTH SUMMARY

Allergies from: Medication/Food/Other:

Allergy	Reaction/Side Effects

Immunizations:

Vaccine	Last Received

Tobacco/Alcohol History:

	Please Circle	Please Circle	Treatment for abuse?	Miscellaneous
Alcohol Use	Yes No	Past Present Never	Yes No	# oz per ____ day ____ week ____ month Type of alcohol: ________________
Tobacco/Vaping Use	Yes No	Past Present Never	Yes No	Type: How Often:

Substance Abuse History:

	Please Circle	Please Circle	Treatment for abuse?	Miscellaneous
Prescription Drug Use	Yes No	Past Present Never	Yes No	Type: How Often:
Recreational Drug Use	Yes No	Past Present Never	Yes No	Type: How Often:

Current Medications: List ALL medications you are currently on, including over the counter, vitamins, and supplements. You may provide a copy of your current medication list if available.

Medication	Dose	Frequency Taken

Pharmacy: IF medications are prescribed or refilled; where do you want the prescription(s) sent?

If.multiple.pharmacies?please.note.which.ones.sent.where?.

Local Pharmacy (specify location: ____

Mail-Order Pharmacy: ____

Current Problems/Medical Diagnosis:

Diagnosis/Condition	Diagnosis Date

Past Medical History: Surgeries & Hospitalizations: (all surgeries and hospitalizations since last physical)

Surgeries	Date
Hospitalizations	Date
Last Annual Physical/Wellness Exam	Date

Specialists/Facilities: (Living Facility, Home Health, Physical Therapy)

Functional Status/Activities of Daily Living/Safety

Marital Status: S M D W Spouse/Partner/Caregiver's Name: ______________

Occupation: __________________/Retired

Sexual History: Active Not Active Current partner: M F Both
Current contraception: None Yes, what? ______________________

Living Arrangements: Alone w/ Spouse/Family in Facility w/ Friend/Roommate
Other:_________________

Advance Care Directives: No Yes

Living Will: No Yes Power of Attorney: No Yes - copy provided?

Do Not Resuscitate: No Yes- on file?

Exercise: None Type (of exercise): __________ Frequency: daily ____days/wk rarely

Have you fallen in the last year? No Yes Devices used to assist with ambulation:(circle one)
None Cane Walker Wheelchair Scooter

How long can you walk or move around at one given time: (circle one) None

(in Minutes) less than 5 5-15 15-30 30-60 1hr or more Unknown

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Review of Systems (ROS)- circle those that apply

CONSTITUTIONAL

Chills
Fatigue
Fever
Unexplained weight gain/loss

EYES

Blurred/change in vision
Glasses/contacts

ENT

Difficulty swallowing
Frequent nosebleeds
Hearing problems
Hoarseness/sore throat
Nasal congestion
Ringing in ears
Sneezing

CARDIOVASCULAR

Chest pain
Dizziness
Fainting
Palpitations
Swelling

RESPIRATORY

Cough
Shortness of breath
Wheezing

GASTROINTESTINAL

Abdominal pain
Bloody or dark stool
Change in appetite
Constipation
Diarrhea
Heartburn
Nausea
Vomiting

OTHER

____
____

GENITOURINARY

Blood in urine
Genital lesions
Painful urination
Penile/vaginal discharge
Urinary frequency
Urinary incontinence
Urinary urgency

MUSCULOSKELETAL

Back pain
Joint pain/swelling
Muscle pain
Muscle weakness
Neck pain

INTEGUMENTARY/ BREAST

Abnormal moles
Breast discharge
Breast mass
Hair/nail changes
Rash

NEUROLOGICAL

Dizziness
Headaches
Loss of balance
Memory loss
Numbness
Seizures

HEMATOLOGIC/LYMPHATIC

Bruising
Excessive bleeding
History of blood clots
History of blood transfusion
Swelling in lymph nodes

PSYCHIATRIC

Anxiety
Depression
Difficulty concentrating
Sleep disturbance
Suicidal thoughts

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Patient Portal Text Messaging Email

Patient Name: _________________________________ DOB: _____/______/__________

ELFHP offers a secure, HIPAA-compliant Patient Portal for our patients. This optional service allows you to review your health records at ELFHP. By signing below, you acknowledge that you have received, read, understand, and agree to follow the guidelines and policies for using the Patient Portal.

The Patient Portal operates through a secure connection. To help maintain this security, we request that you provide a private email address for portal access. Please keep your user ID and password confidential. If you believe your password has been compromised, contact our office immediately so we can assist you with updating it.

Please note: The Patient Portal does *not* support two-way communication between patients and providers and is not intended for messaging. Any questions regarding your health should be directed to our office by phone.

Please check mark one box below:

☐ I would like to sign up for ELFHP's secure Patient Portal
Email Address: ____

☐ I do NOT wish to sign up for ELFHP's secure Patient Portal

I consent for ELFHP to provide appointment confirmation messages and reminders via text message and/or email. ELFHP may also send practice updates and, when necessary, contact me by text or email regarding scheduling, account matters, or when phone attempts have been unsuccessful. Initial messages will not include private health information; such information will only be shared via text or email if I provide verbal consent.

Patients are responsible for contacting the office **by phone** if they are unable to attend an appointment and need to cancel, reschedule, or make changes.

I agree to notify ELFHP if my mobile/cellular number changes or if it is no longer in my possession.

____ ______________________

Signature of Patient/Legal Guardian *Date*

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Practice Policies

Your understanding of our policies is important to maintaining a positive practice–provider–patient relationship. If you have any questions regarding our office policies, please contact our office.

Healthcare Programs

Our practice partners with One Health of Nebraska ACO (Accountable Care Organization). An ACO is a program designed to improve primary care by giving providers additional support and resources to help you receive better, more coordinated care. Our goal is to provide the highest quality, patient-centered care.

Information for Traditional Medicare (Part A and Part B) Beneficiaries: To help us better manage your care, Medicare will begin sharing certain personal health information with us. This information allows us to gain a more complete picture of your health needs.
If you prefer that Medicare not share this information, please notify us as soon as possible.

No-Shows / 10-Minute Policy

If you are unable to keep your scheduled appointment, please notify our office at least 24 hours in advance. Arrival 10 minutes or more past your appointment time is considered a “no-show,” and you may be asked to reschedule.

We make multiple courtesy appointment reminders by phone/text. However, technology can fail, so please do not rely solely on reminders—be sure to make your own notation as well.

Repeated no-shows and lateness may result in dismissal from the practice.

Participating Insurances

We participate with most insurance plans; however, we recommend that you contact your insurance provider to verify that our providers are in-network.

Insurance Claims

Your insurance policy is a contract between you and your insurance company—our office is not a party to that contract.
To properly bill your insurance, you must provide complete and accurate insurance information, including any updates. Failure to do so may result in patient responsibility for charges.

- If we are in-network: you agree to pay any portion of the charges not covered by insurance.
- If we are out-of-network and your insurance pays *you* directly: you are responsible for payment and agree to forward that payment to us promptly.

If we cannot verify your insurance coverage: you agree to pay for the services at the time they are provided or you may reschedule your appointment. Once coverage is obtained, claim will be submitted and any applicable credit will be refunded once claim has been processed.

Co-Pays

All patients must present their insurance card at each visit.
Co-pays and past due balances are due at check-in, unless prior arrangements have been made.
We accept cash, check, credit, and debit cards.

Past Due Accounts

Our office policy requires that all balances be paid. When you or a family member checks in for an appointment, staff will collect:

- Co-pays
- All current and past due balances

Monthly statements are sent for accounts with balances, with a minimum of four statements mailed.

If there is no communication regarding a past due account and no payment arrangement is made or kept, the account will be sent to collections. You and your family members may also be subject to dismissal from the practice.

We attempt to notify patients regarding past due accounts by text message and by mailing a Final Request letter.

If you receive such a letter, all associated accounts will be placed on Insurance Submission/Cash/Self-Pay status for a period of time. While we will continue to submit claims to your insurance, we will also collect a minimum of $190 at check-in for each visit. Once insurance processes the claim, any applicable credit will be refunded.

Accounts must remain current, and balances must be paid within 30 days of the statement date.

Payments may be made:

- In person
- By mail
- Over the phone
- Through our website (Pay Your Bill tab)

Self-Pay Accounts

Self-pay accounts include patients without insurance or patients covered by insurance plans in which we do not participate.
Payment in full is collected prior to being seen.
Liability cases are also considered self-pay.

Motor Vehicle Accident (MVA) and Third-Party Billing

You will receive an accident questionnaire, which must be completed and returned. As a courtesy, we will submit claims to the carrier listed.

If the questionnaire is not returned or the claim is denied, you will be responsible for payment in full.

We collect $175 prior to each MVA appointment until insurance coverage is confirmed.

Workers' Compensation

It is the patient's responsibility to provide employer authorization and contact information for a workers' compensation claim.

If the claim number along with the WC/employer information to file the claim cannot be provided, patient will be responsible for payment in full. If workers' compensation denies the claim, it becomes the patient's responsibility. At your request, we will submit the claim to your primary medical insurance along with the denial. If your primary insurance denies the claim, you are responsible for payment in full.

Returned Checks

There is a $35 fee for returned checks, payable by cash or money order, in addition to the original insufficient funds amount.
You may be placed on a cash-only payment status following a returned check.

Medical Record Copies

Fees for medical record copies:

- $20.00 + $0.50 per page- paper
- $20 flat fee- electronic/disc

Referrals and Prior Authorizations

Some insurance plans require referrals or prior authorizations from your Primary Care Provider before specialist visits, scans, or certain tests.

It is your responsibility to know whether your insurance requires this.
Failure to obtain the necessary referral/authorization may result in reduced or denied coverage, making the balance your responsibility.

Non-Covered Services

Certain services are not covered by insurance and fall outside standard medical care. These may include:

- Letters
- FMLA forms
- Disability forms
- Insurance report forms

A reasonable fee will be charged prior to completion of these services.

CDL/DOT Physicals

CDL/DOT physicals determine whether an individual is medically qualified to operate a commercial motor vehicle.

These physicals are not covered by insurance.
Payment of $130 is required prior to being seen.

Personal Information Provided

By providing your phone number(s) and email address(es), you consent to being contacted by our office and coordinating providers through calls, voice messages, texts, or emails.

If you obtain a new phone number or email address, it is your responsibility to update our office. This consent remains effective unless revoked in writing.

Other Helpful Items to Note:

Call Us First

You may be able to avoid an ER visit or a trip to urgent care by calling our office first. **402-483-7507**

Office Hours and **non-Office Hours**, we are available **24 hours 7 days a week**.
During non-office hours (evenings, nights & weekends) one of our providers can assist with acute needs or urgent questions.

Inclement Weather Policy- The office will notify patients who are scheduled if we open late or are closed for the day. Reminder messages will be sent out via phone calls or text messages. We do encourage patients to call the office before travelling to your appointment if weather conditions are questionable.

Prescription Policy- The office will not prescribe any new medications generally without an appointment. Controlled medications will be refilled ONLY during an appointment. Medications for conditions that are being monitored may need an appointment every 1 to 3 months. Maintenance medications that are stable and no changes are needed will be considered for a year refill at an Annual Wellness Visit/Physical.
If you have medication requests or questions, it is always best to directly speak with the pharmacy and not the automation as it can be incorrect. If you change pharmacies, please notify our office as we will need to cancel any prescriptions at the previous pharmacy. Please allow 5-7 working days for medication refills. Medications needing approval by your insurance may take up to 3 weeks for us to complete the request.

Lab Policy- Our office partners with an outside laboratory for processing certain specimens that are not completed in-house. These typically include blood samples drawn into tubes and culture specimens.
We perform finger-stick tests and rapid swabs in our office for acute illnesses, such as strep throat or influenza. All other applicable specimens are sent to Physlab along with your insurance information and the diagnosis related to the ordered tests. Please note that you may receive a separate bill from the laboratory for these services. If you receive a statement, we ask that you contact the phone number listed on the bill first. If you still need assistance afterward, you are welcome to call our office for additional help.

By signing this, I agree and will abide by the policies of East Lincoln Family Health Professionals, PC.

________________________________ ________________________

Patient/Legal Guardian Signature Date

____

Patient Name

Role of Our Providers

Our goal is to provide you with the highest-quality, professional medical care. Our healthcare team works together to support your needs, help you feel better, and partner with you in reaching your health goals.

To help you better understand how we work as a team, here are some helpful points:

- One unified chart: Every patient has a single medical chart. All providers access the same records, ensuring consistency and continuity of care.
- Collaborative approach: Our providers consult with each other when needed to ensure the best care and clinical decision-making.
- Shared roles: Physicians and Physician Assistants function in the same role within our office. All provide primary care, including diagnostic evaluations, treatment plans, preventive care, and in-office surgical procedures.
- Ongoing education: Our providers meet monthly to review clinical topics, collaborate on cases, and stay current with medical updates.
- Leadership: Dr. Sawtelle, our Lead MD, provides clinical guidance and support to the entire provider team.
- Trusted team: Dr. Sawtelle has the utmost confidence in our providers and their ability to deliver excellent primary care to our patients.
- Value of Physician Assistants: Our Physician Assistants play an essential role in our practice, bringing medical-model training and extensive experience in caring for patients.
- Patient–provider relationships: We recognize that patients often prefer to see the provider with whom they have established care, and we do our best to honor those preferences whenever possible.

How You Can Help

There are times—such as provider absences, high volumes of acute illness, or unusually busy schedules—when your preferred provider may not have immediate availability. When this happens, our staff will offer you the best options, which may include seeing another provider you have not seen before. Based on the urgency and reason for your visit, our priority is always to ensure that you receive timely and appropriate medical care. Please know that all providers communicate closely and work as a team in caring for you.

For non-urgent appointments or follow-ups that are several weeks or months out, we are typically able to schedule you with the provider you prefer.

A Helpful Tip for Annual Visits

If you have a provider you prefer for your Annual Wellness Visit, Physical, or Well-Child Check, we encourage you to schedule your next year's appointment when you are here for your current AWV/PX/WCC. This helps secure the provider and time that works best for you.

Your Guide to Understanding Medical Coding, Billing & Insurance

At ELFHP we know medical bills and insurance terms can be confusing. Our goal is to help you feel informed and confident about what you see on your statements. Below is a simple guide to help explain how medical coding and billing works—and why you might notice differences from one visit to the next.
Always compare your insurance EOB to your provider's bill to ensure they match. If something seems unclear, we're happy try to explain it we're Here to Help-with questions about your bill, your insurance EOB, or why a specific code appears—please don't hesitate to reach out. We're committed to making healthcare billing as easy to understand as possible.

What Is Medical Coding & Billing?

When you visit our office, everything your provider does—like reviewing your medical history, performing a check-up, or managing a condition—is documented. This information is then translated into standard codes used across the U.S. healthcare system.

These codes are:

- Sent to your insurance company to request payment for the services provided
- Reviewed by your insurance to determine what they'll cover and what portion (if any) becomes your responsibility

Think of it like a receipt written in "medical language" to communicate with your insurance provider.

Why E&M Visit Levels May Vary

E&M stands for Evaluation and Management, which is the type of code used for most office visits.

The "level" of an E&M code depends on:

- The complexity of your condition(s)
- The amount of decision-making involved
- The time spent on your care during the visit -keep in mind, while time is one factor; it's not only time spent in the exam room- it includes work done Before & After your visit.

So, even if two visits seem similar, they may be billed differently based on what was discussed or managed during that specific appointment.

For example:

A quick visit for a sore throat = lower level

A longer visit reviewing lab results and managing multiple health issues = higher level

---

What Is CPT Code G2211—and Why Is It on My Bill?

You may see G2211 listed as a small charge.

This code is used when your provider is:

- Your main point of contact for ongoing care
- Managing chronic or complex conditions
- Spending time behind the scenes reviewing your history, test results, or coordinating your care
- G2211 is Medicare's way of recognizing the extra time and effort your doctor puts into managing your overall health—not just what happens in the exam room.

Why Did I Get a Bill When I Came in for My Routine Physical?

Many insurance plans cover one preventive physical per year at no cost to you. However, if you discuss new concerns, symptoms, or medical issues during that same visit, it may be billed separately with modifier 25.

If you came in for a routine physical but also discussed a separate issue (like new symptoms or a chronic condition), we may bill that part of the visit using modifier 25.

This allows your insurance to understand that two different types of services were provided on the same day:

- Preventive exam (covered annually)
- Evaluation of a separate problem (may apply to your deductible or copay)

This is a standard and ethical billing practice used nationwide.

Who Sets the Cost of My Visit?

It’s important to know:

Our office does not set the final cost of your visit.

We follow standard CPT (Current Procedural Terminology) codes, and your insurance company determines how much they’ll pay for each code.

We charge based on what is allowed by your insurance. Your portion (if any) is determined by:

- Your specific insurance plan
- Whether you’ve met your deductible
- Your copay or coinsurance requirements

How to Read Your Insurance EOB (Explanation of Benefits)

After your visit, you’ll receive an EOB from your insurance. This is not a bill—it’s a summary of:

- The services billed by our office
- What your insurance covered
- What you may owe (copay, coinsurance, or deductible)

Common terms what you may see on your EOB:

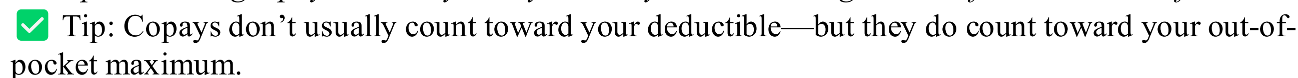
💰 1. Deductible- the amount you must pay out of your own pocket before your insurance starts covering costs.

Example: If your deductible is $1,500, you pay the first $1,500 of your medical expenses each year before insurance pays.

✅ Tip: Deductibles reset every year—check when yours starts over!

💳 2. Copay- a set fee you pay at the time of your visit.

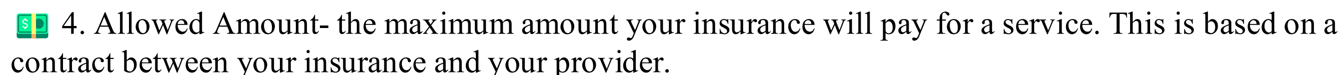
Example: You might pay $25 every time you visit your doctor, regardless of the total cost of the visit.


✅ Tip: Copays don’t usually count toward your deductible—but they do count toward your out-of-pocket maximum.

🧾 3. Coinsurance- the percentage you pay after your deductible is met.

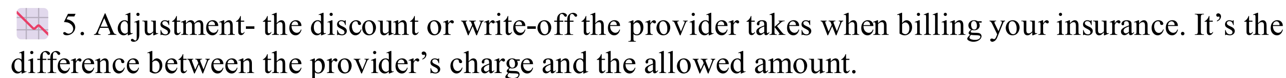
Example: If your coinsurance is 20% and your doctor visit costs $100, you pay $20, and insurance pays $80.

✅ Tip: Coinsurance kicks in after your deductible is met.


💵 4. Allowed Amount- the maximum amount your insurance will pay for a service. This is based on a contract between your insurance and your provider.

Example: If your doctor charges $150 but the allowed amount is $100, insurance pays based on the $100, not the full charge.

✅ Tip: You are not responsible for the difference between the provider’s charge and the allowed amount when seeing an in-network provider.


📉 5. Adjustment- the discount or write-off the provider takes when billing your insurance. It’s the difference between the provider’s charge and the allowed amount.

Example: If the doctor charges $150, and the allowed amount is $100, the $50 is adjusted off—you don't pay it.

✅ Tip: This amount is not billed to you.

Consent for Treatment, Payment, and Healthcare Operations-HIPAA Notice of Privacy Practices

I consent to the use and disclosure of my Protected Health Information ("PHI") by East Lincoln Family Health Professionals, PC ("ELFHP") for purposes of treatment, payment, and healthcare operations, as permitted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 CFR Part 2, and applicable state law.

I understand that ELFHP may use and disclose my PHI to diagnose and treat me, obtain payment for healthcare services, and conduct healthcare operations, including quality improvement, care coordination, training, accreditation, credentialing, and administrative functions. I understand that my receipt of healthcare services may be conditioned upon signing this consent.

ELFHP limits uses and disclosures of PHI to the minimum necessary to accomplish the intended purpose, except where disclosures are made for treatment or otherwise permitted by law.

I understand that I have the right to request restrictions on certain uses and disclosures of my PHI for treatment, payment, or healthcare operations. ELFHP is not required to agree to any requested restriction; however, if ELFHP agrees, it will comply with the restriction except as otherwise permitted by law.

I understand that I have the right to revoke this consent in writing at any time, except to the extent that ELFHP has already relied on this consent to take action.

Protected Health Information (PHI) includes information that identifies me and relates to my past, present, or future physical or mental health condition, the provision of healthcare to me, or payment for healthcare services. This information may be created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse.

I acknowledge that I have the right to review the East Lincoln Family Health Professionals, PC Notice of Privacy Practices and the Patient Services and Rights Agreement before signing this consent. These documents explain how my PHI may be used and disclosed and describe my privacy rights under HIPAA. Copies are available upon request at any time.

I understand that psychotherapy notes and substance use disorder counseling notes require separate written authorization and are not covered under this general consent, except as permitted by law.

I understand that information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy laws, except where otherwise restricted.

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). Federal law prohibits you from making any further disclosure unless expressly permitted by written consent of the individual or as otherwise permitted by law.

I understand that federal law prohibits the redisclosure of records from federally assisted substance use disorder programs without my written consent, except as permitted under 42 CFR Part 2 or by court order.

I understand that disclosures may include sensitive health information, such as alcohol or drug use, mental or behavioral health information, sexually transmitted infections, HIV/AIDS status, or self-pay services, as permitted by law.

I understand that I may revoke this authorization at any time by submitting written notice or a completed Revocation of Authorization form to ELFHP. Revocation will not affect disclosures or actions already taken prior to receipt of my revocation. ELFHP may continue to use PHI as necessary for lawful billing and collection of services rendered.

I understand that I may file a complaint with ELFHP or with the U.S. Department of Health and Human Services if I believe my privacy rights have been violated. I will not be retaliated against for filing a complaint.

ELFHP reserves the right to revise its privacy practices as described in its Notice of Privacy Practices. I may obtain an updated Notice by contacting the office or requesting a copy at my next appointment.

Acknowledgement signature is required on the Demographic Form.