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

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

Bradley Sawtelle, MD
Andrea Hegge, PA-C
Jenna Riley, PA-C
Krystal Jackson, PA-C

New Patient Paperwork

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 Messaging/Email Consent
- ROI (Family/Friend)
- Medical Records Request (to obtain your previous PCP records)
- Health History

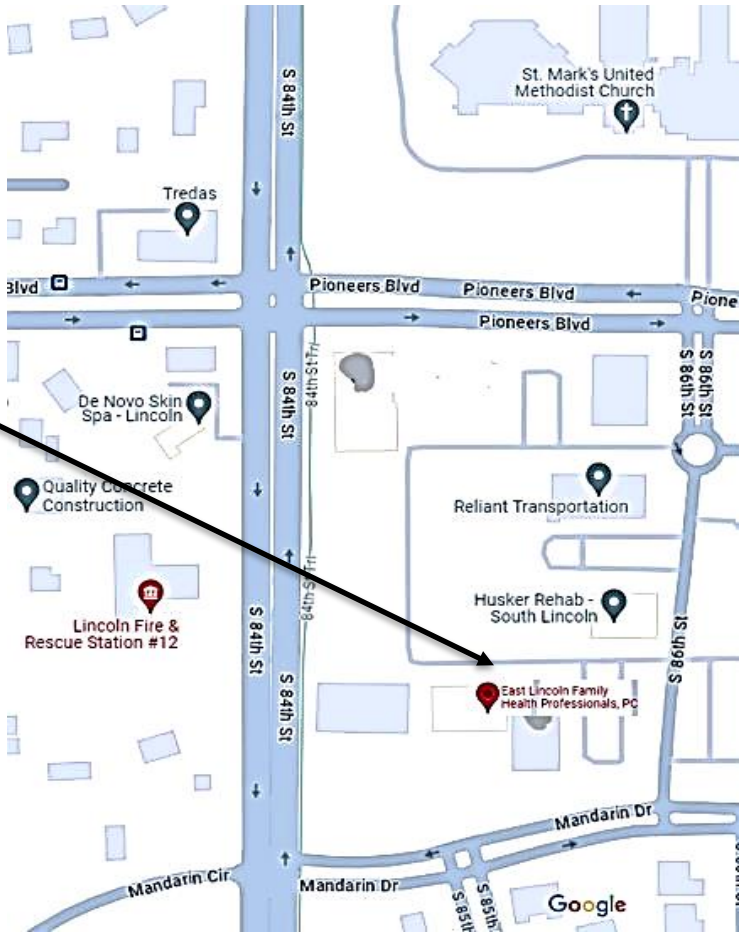
We ask that you arrive at least 20 minutes prior to your scheduled appointment to allow us time to go over your paperwork and gather all your insurance information. Please bring both your insurance card(s) and Driver's License (or photo ID) with you, as we need them to properly bill your insurance and 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).

Where we are located:
4525 S 86TH ST, Suite B, Lincoln NE 68526

Off of 84th and Pioneers Street.
Located in the Pioneer Greens complex.
Look for a red awning at our front door with ELFHP letters.
Entrance faces the north.

We are here.



Helpful Notes about ELFHP

Once you are established, you can Call Us First.
You may be able to avoid an ER visit or a trip to urgent care by calling our office first. Office hours and non-office hours, we are available 24 hours a day, 7 days a week.
During non-office hours (evenings, nights & weekends) one of our providers can assist with acute needs or urgent questions.

Practice Policies

Your understanding of our policies is important to our practice-physician-patient relationship. If you have any questions regarding our office policies, please give our office a call.

Healthcare Programs

Our practice partners with One Health of Nebraska ACO. Accountable Care Organization (ACO) is a program to improve primary care by giving providers extra support to help you receive better care. Through ACOs, our insurers will give our practice additional resources to help us better manage your care. We hope to provide you with the highest quality patient-centered care.

More information for traditional Medicare (Part A and Part B) beneficiaries

To help us take better care of you, Medicare will start sharing some of your personal health information with us. This information will help provide us a more complete picture of your health so we're better able to coordinate your care. If you want to stop Medicare from sharing this information, please let us know as soon as possible.

No-Shows/10 Minute Policy

We ask that if you are not able to make your scheduled appointment, you please contact our office within 24 hours of the appointment. We do consider an arrival of 10 minutes or more past the scheduled appointment time a "no-show" and may ask you to reschedule. We do provide multiple courtesy reminder phone calls/texts of the scheduled appointment. However, technology can fail so we ask you not to solely rely on the reminder call. Please make your own reminder in your schedule. Continuous "no-shows" may result in termination from our practice.

Participating Insurances

We participate with most insurances, however do recommend you contact your plan to verify our providers are in-network.

Insurance Claims

Your insurance policy is a contract between you and your insurance company - we are NOT a party to this contract. In order to properly bill your insurance, we require that you disclose all insurance information, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the services. If we are in-network with your insurance, you agree to pay any portion of the charges not covered by insurance. If we are out-of-network with your insurance, and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us promptly.

Co-pays

All patients are expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made. We accept cash, check, and credit or debit card.

Past Due Accounts

It is our office policy to collect any balance that is due. If you or a family member have an appointment, staff will be collecting copays, and ALL current and past due balances. Statements may not have been generated for current balances; however, we can provide one at check-in. Accounts with a balance will be sent a minimum of 4 statements: one each month. If there has been no communication with our office regarding the past due account(s), payment arrangement not discussed, set-up, and/or kept as agreed upon, the account will be sent to the collection agency. Also, you and possibly family members may be subject to being released from the practice. Our office will make attempts to notify you if your account is past due. Text messages and a Final Request letter will be sent. If you or a family member should receive a letter regarding past due amounts, all accounts associated will be placed on Insurance Submission/Cash/Self Pay status for a period of time. This means we will continue to submit claims to the insurance you provide but we will also collect a minimum of $175 (this amount is subject to change) at the time of visit when you check in for your appointment. Once your insurance processes the claim, if there is any credit on the account, it will be refunded. You will also be billed for any additional patient responsibility amounts insurance indicates that were not paid. The time period in which account(s) remain in this status may vary depending on account history for the need to re-establish reliable account credit with our office. Any accounts with balances will need to be kept current

and have balances paid within 30 days of statement issued. Payments can be made in person, mailed, you can call our office and pay over the phone, or we offer secure payment through our website at www.eastlincolnhealth.com by clicking on the "Pay Your Bill" tab.

Self-pay Accounts

Self-pay accounts are patients without insurance coverage or patients covered by insurance plans in which the office does not participate. Prior to being seen, we will collect payment in full. Liability cases will also be considered self-pay accounts.

Motor Vehicle Accident (MVA) and Third-Party Billing

You will receive an accident questionnaire to be completed. As a courtesy, we will submit the claim to the insurance carrier provided on the form. It is your responsibility to seek reimbursement from them. If the questionnaire is not returned or completed and/or we receive a denial on your claim, you will be responsible for payment in full. We collect $175 prior to every MVA appointment until insurance picks up the claims.

Workers' Compensation

It is the patient's responsibility to provide our office staff with employer authorization/contact information regarding a workers' compensation claim. If the claim is denied by the workers' compensation insurance carrier, it then becomes the patient's responsibility. At your request, we will submit the claim to your primary medical insurance carrier with a copy of the workers' compensation insurance denial. If your primary medical insurance carrier's claim is denied, you will be responsible for payment in full.

Returned Checks

There is a $35 charge for a returned check payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Medical Record Copies

Patients requesting copies of medical records will be charged:
$20.00 + $0.50 per page for paper records. $20 flat fee for records imported on a disk.

Referrals and Prior-Authorizations

Certain insurances require that you obtain a referral or prior-authorization from your Primary Care Provider (PCP) before visiting a specialist, or having certain scans or tests performed. If your insurance company requires a referral and/or prior-authorization, you are responsible for knowing. Failure to obtain the referral and/or prior-authorization may result in lower or no payment from the insurance company, and the balance will be your responsibility.

Other Non-Covered Services

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. These services might include writing a letter, FMLA form completions, insurance forms, or disability forms. Under those circumstances, a reasonable charge will be requested prior to completing the requested services.

CDL/DOT Physicals

CDL/DOT physicals are health examinations needed to determine if a person is capable of operating a commercial motor vehicle. These physicals are not covered by insurance, meaning we will collect payment in full prior to being seen. A CDL/DOT physical costs $125.

Personal Information Provided

You understand and agree that any phone numbers and email addresses provided by yourself to this office, now and in the future, may be used as a means to contact you. The office and any coordinating providers may leave voice messages, texts, or emails by means of contacting you. In the future, should you acquire a new phone number, you understand it is your responsibility to update our office with that information and this consent would stay effective.

_____ _____

Signature of Patient/Legal Guardian *Date*

Demographics - Page 1

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

Contacts:

Legal Guardian *(please circle):* **Self** **Other:** _____

☐ POA/Legal Guardian Paperwork on file

Guarantor Information *(who is responsible for bills/statements)*

Name: _____ **Relationship:** _____
Last First

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

Name: _____ **Relationship:** _____
Last First

Phone Number: _____

Demographics – continued Page 2

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:

- 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 or not their own legal guardian, permission is hereby given to ELFHP to treat the patient, without the presence of a parent or guardian.

    Examination, in office procedures, laboratory testing, vaccines, X-ray, administration of medication(s), other care/services. I grant authorization and consent for East Lincoln Family Health Professionals to administer medical treatment for any minor injuries or illnesses experienced by the minor.

    It is in the best interest that children are brought and accompanied by a parent or legal guardian to their appointments. However, there may be times that someone other than the parent(s) or legal guardian will bring your child; or for children 16-18 years of age who are able to drive themselves to the office. During these times, we need your consent allowing ELFHP to treat your child.

_____ _____

Signature of Patient/Legal Guardian *Date*

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

Patient Portal

Patient Name: _____ DOB: _____/_____/_____

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

The Patient Portal uses a secure connection. To help ensure our connection remains secure, we ask that you provide us with your private email address. Always keep your user ID and password secure. If you think your password has been shared, please notify our office immediately so we can instruct you on how to change it.

Please note: The Patient Portal does not have the functionality of back and forth communication between patient and provider and is not meant to be used for that. Questions pertaining to your health should be addressed via phone call.

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

_____ _____
Signature of Patient/Legal Guardian *Date*

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

Text Messaging and Email Consent

Patient Name: _____ DOB: _____/_____/_____

ELFHP offers appointment confirmation messages and reminders by text message and/or email.

We also will share practice updates by text and email.

If you wish to receive these text messages and/or emails, please read the disclaimer below then complete and sign this form.

I consent to East Lincoln Family Health Professionals contacting me by text message and/or email for the purpose of appointment reminders, notifications, and practice updates. I also understand standard text messaging rates may apply.

I acknowledge that the responsibility of attending appointments and cancelling them still rests with me and will need to call into the office to cancel or change the appointment. I can opt out of the text and/or email function at any time.

I agree to advise ELFHP of my mobile number and/or changes if no longer in my possession.

Please sign below:

_____ _____

Signature of Patient/Legal Guardian *Date*

☐ *I choose to opt out of the text messages and email feature.*

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

Authorization to Release Information to Family/Friend

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, PC 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*

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

Authorization to Request/Release Protected Health Information

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

Parent/Legal Guardian Name (if applicable): _____

For the **purpose of**:

- ◯ Transferring of Care
- ◯ Specialist/Continuity of Care
- ◯ Workman's Compensation/3rd Party Claim
- ◯ Other: _____

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

- ◯ ALL available information - COMPLETE Medical Record
- ◯ Immunization Records
- ◯ Medical Records generated from the following date(s): _____
- ◯ 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 before my revocation letter 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 below (if applicable):

FROM or TO: East Lincoln Family Health Professionals, PC 4525 S 86th ST, STE B, Lincoln NE 68526

Please circle *Phone: 402-483-7507 Fax: 402-483-6899*

TO or FROM: Facility/Provider: _____

Phone: _____ *Fax:* _____

_____ _____

Signature of Patient/Legal Guardian *Date*

As you are completing these forms, please feel free to write on the back of the forms if there is not enough space or you need more room

Family Health History

Condition	Mother	Father	Sister	Brother	Other
Age of Death/Cause					
ADD/ADHD					
Alcoholism					
Alzheimer's					
Anxiety					
Asthma					
Bipolar Disorder					
Bleeding Disorder					
Cancer/Type					
Depression					
Diabetes					
Drug Abuse					
Glaucoma					
Heart Disease (Congestive Heart Failure, Heart Attack, Other)					
High Blood Pressure					
High Cholesterol					
Kidney Disease					
Migraines					
Osteoporosis					
Rheumatoid Arthritis					
Stroke					
Thyroid Disorder					

Past/Present Patient Health Screening

Medication/Food Allergies:

Allergy	Reaction/Side Effects

Med List: All medications you are currently on, including over the counter, vitamins, and supplements. If you filled out a separate medication list, please check mark and attach below. ☐ Separate medication list attached.

Medication	Dose	Frequency Taken

Medical Diagnosis/Conditions:

Diagnosis/Condition	Diagnosis Date

Please provide us with a record of your immunizations.

Surgeries & Hospitalizations: (all surgeries and hospitalizations since last annual physical)

Surgeries	**Date**
Hospitalizations	**Date**

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

Drug/Alcohol Use: (please complete all follow up questions for each substance)

	Please Circle	**Please Circle**	**Frequency**	**Miscellaneous**
Alcohol Use	**Yes No**	**Past Present Never**		**Treatment for alcohol abuse? Yes No**
Caffeine Use	**Yes No**	**Past Present Never**		**What kind?**
Tobacco/Vaping Use	**Yes No**	**Past Present Never**		**Type:**
Prescription Drug Abuse	**Yes No**	**Past Present Never**		**What drug?**
Recreational Drugs	**Yes No**	**Past Present Never**		**Type:**

Social:

Sexual Activity	**Yes No**	**Partner?**	**Using birth control?**	**Previous STI?**

Marital Status:	**Occupation:**
Number of Children:	**Exercise: Yes No | Frequency:**
Do you have a Living Will? Yes No	**Do you have a medical or any other POA? Yes No**

Review of Systems (ROS)

PATIENT NAME:_____ DOB:_____

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
___ or dark stool
___ Change in appetite
___ Constipation
___ Diarrhea
___ Heartburn
___ Nausea/Vomiting

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

OTHER

- _____
- _____
- _____