Patient Agreement

1. **CONSENT TO TREAT.** I hereby authorize Essential Family Medicine of Omaha and its employees and agents to examine me/the patient named below and to furnish diagnostic and therapeutic services as they deem necessary and appropriate.

2. **CONSENT ON BEHALF OF ANOTHER PATIENT.** If I am authorizing on behalf of someone other than myself (a child, or an individual with whom you are guardian/Power of Attorney) I give consent to any and all medical care and attention deemed necessary and appropriate by the medical personnel in this office that are licensed by the state of Nebraska. This consent includes but is not limited to, examinations, surgical procedures, treatment, injections, obtaining laboratory testing or x-rays to make a diagnosis, and prescribing medication. This delegation of consent shall be valid until I withdraw delegation of consent.

List any other adult(s) you authorize to present the patient for care at Essential Family Medicine

Name	***Relationship to Patient***

3. **FINANCIAL RESPONSIBILITY.** I have been offered the information regarding the financial responsibility and agree to the terms and conditions set forth in the Financial Policy. I understand that I am responsible for and agree to pay all charges regardless of insurance coverage or pendency of claims. I authorize the release of all medical information necessary to process my health insurance claim and request payment of benefits be made to Essential Family Medicine of Omaha, L.L.C.. A photocopy of this agreement shall be as valid as the original. I understand that I can withdraw this medical benefit assignment at any time by notifying this office in writing.

I acknowledge I have read, understand, and agree to the information set forth above, and I certify that if I am not the Patient, I am legally authorized to sign for the Patient.

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

_____

Signature of Patient/Parent/Responsible Party Relationship to Patient

_____/_____/_____

Witness Date

CONTACT AUTHORIZATION

Patient Name:	Date of Birth

Essential Family Medicine is committed to protecting our patient's privacy. Without your authorization, messages left on voicemail or with other individuals will be limited. The only information left will be limited to our office name and phone number. If you prefer more complete information be provided, please fill out the form below.

Please contact me as follows:

Best daytime contact #:_____

☐ Leave **limited** message-only provider name and phone #
☐ Leave **detailed** message-lab/test results, med changes, etc.

Any written communication will go to the address on file.
Please verify we have your current address.

I hereby give permission to release my medical information to the following individuals (examples: spouse, children, sibling, friend, etc.). This includes but is not limited to lab or x-ray results, immunizations & injections, prescription medication information, surgical information, exam information, or treatment:

- _____
- _____
- _____

By signing below I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ Date:_____