Essential FAMILY MEDICINE

Patient Information

PATIENT LEGAL NAME_____Sex ☐M ☐F
(LAST) (FIRST) (MIDDLE)

Address_____City_____State_____Zip_____

☐ Primary Phone_____ ☐ Cell_____ ☐ Work_____
****Check Preferred Contact Number**

SS#_____/_____/_____ DOB_____/_____/_____ Race_____ Ethnicity: Hispanic/Latino or Non Hispanic/Latino
***circle one**

Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ O Spouse _____ Phone_____

Employment Status: ☐ Yes ☐ No ☐ Retired Employer_____

Email_____

If Patient is a Minor or Student:

Mother's Name_____ Phone_____

Father's Name_____ Phone_____

Referring Physician_____ Primary Pharmacy_____

Emergency Contact Information

Full Name_____ Phone_____ Relationship_____

Health Insurance Information

Primary Ins._____

Policy Holder_____ SS#_____/_____/_____ DOB_____/_____/_____

Secondary Ins._____

Policy Holder_____ SS#_____/_____/_____ DOB_____/_____/_____

Responsible Party_____ SS#_____/_____/_____ DOB_____/_____/_____

Address_____City_____State_____Zip_____

Employer/Address_____ Relationship to Patient_____

☐ Primary Phone_____ ☐ Cell_____ ☐ Work_____
****Check Preferred Contact Number**

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.

This includes any and all treatment necessary due to a motor vehicle accident._____ (please initial)

CANCELLATION & NO-SHOW APPOINTMENT FEE: Please notify our office at least twenty-four (24) hours prior to your appointment time to let us know if you are unable to keep your appointment. We reserve the right to charge you a fee of $35.00 for 1st offense and $50.00 for each additional missed appointment when the office is not given a 24 hour notice. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple non-cancelled missed appointments may result in a patient being discharged from our practice.

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

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CONTACT AUTHORIZATION

Patient Name: Please Print	DOB:

If patient is a Minor please fill out below: Please Print

Guardian Name and relationship to patient:	Phone #

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 given will be limited to our office name and phone number.

Please Contact me as follows: If a box is not checked we will only leave a limited message

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. If we are unable to reach you by phone a letter will be sent. 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, imaging results, immunizations & injections, prescription medications, surgical information, exam information or treatment:

Please include name and phone number if not listed above

- _____
- _____
- _____

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

Signature of Patient/Guardian:_____Date:_____

Essential FAMILY MEDICINE

PRIVACY NOTICE WRITTEN ACKNOWLEDGEMENT

☐ I have received the Essential Family Medicine of Omaha Notice of Privacy Practices. (Note: My signature does not indicate that I have read, understood or agree with the Notice only that it has been provided to me.)

_____ _____
Signature of Patient/Parent/Legal Guardian Date

_____
Relationship to Patient (if not the patient)

Documentation of Good Faith Effort

☐ Attempted to distribute the Notice of Privacy Practices to the patient/parent/legal guardian, but the patient, parent, legal guardian declined to acknowledge the receipt to the Notice of Privacy Practice.

☐ Patient/Parent/Legal Guardian directed to Essential Family Medicine of Omaha website to view the Notice of Privacy Practices.

☐ The Notice of Privacy Practices was mailed to the patient/parent/legal guardian on _____(date).

☐ Other _____

_____

_____ _____
EFM Employee Date