PATIENT INFORMATION

PLEASE FILL IN ALL INFORMATION REQUESTED ON THIS FORM

LEGAL NAME_____MI____ DATE OF BIRTH_____

MAILING ADDRESS_____ SOCIAL SECURITY#_____

CITY_____STATE_____ZIP_____ SEX: M F MARITAL STATUS: S M D W

HOME PHONE_____ CELL PHONE_____

EMPLOYER_____ WORK PHONE_____

PHARMACY_____LOCATION_____ **REASON FOR VISIT**_____

PRIMARY CARE PHYSICIAN_____ ETHNICITY_____

EMERGENCY CONTACT_____ RACE_____

EMERGENCY CONTACT PHONE#_____ EMERGENCY CONTACT RELATIONSHIP TO PATIENT_____

PREFERRED LANGUAGE (IF OTHER THAN ENGLISH)_____

RESPONSIBLE PARTY INFORMATION (If other than patient)

PERSON RESPONSIBLE FOR THE BILL

NAME_____ SOCIAL SECURITY#_____

RELATION TO PATIENT_____ PHONE#_____ DATE OF BIRTH_____

FULL ADDRESS_____ EMPL OYER_____

INSURANCE COVERAGE INFORMATION

*****INFO NEEDS TO BE COMPLETED EVEN THOUGH A COPY WILL BE MADE*****

NAME OF INSURANCE_____ ID/MEMBER#_____ GROUP#_____

NAME OF SUBSCRIBER_____ SOCIAL SECURITY #_____

RELATION TO PATIENT_____ PHONE#_____ DATE OF BIRTH_____

FULL MAILING ADDRESS_____ EMPLOYER_____

SECONDARY INSURANCE COVERAGE INFORMATION

IF APPLICABLE, NEEDS TO BE FILLED OUT

NAME OF INSURANCE_____ ID/MEMBER#_____ GROUP#_____

NAME OF SUBSCRIBER_____ SOCIAL SECURITY #_____

RELATION TO PATIENT_____ PHONE#_____ DATE OF BIRTH_____

FULL MAILING ADDRESS_____ EMPLOYER_____

****PLEASE COMPLETE BOTH SIDES OF REGISTRATION DOCUMENT****

Urgent Care Clinic of Lincoln Phone/Fax/Email Consent to Leave Messages

At, Urgent Care Clinic of Lincoln, we may need to contact you about test results, appointments, referral or billing/insurance information. By filling out the information below we will be better able to serve you. In an effort to protect your privacy and follow federal guidelines, we have developed the following protocol on leaving medical messages. Unless we have written permission to do so:

****We will NOT leave messages with anyone except the patient or the legal guardian
****We will NOT leave messages on voicemail or answering machines
****We will NOT send emails or faxes

I, _____ give my permission for Urgent Care Clinic of Lincoln to leave phone messages and/or fax messages regarding my medical care/account information. I fully understand that this consent will remain valid until revoked in writing by me.

Patient Name:_____ Date of Birth:_____

E-Mail Address*_____

May we leave Messages to inform you that the test results are available and for you to contact our office for those results? Yes/No If yes, phone number_____

Please verify below and carefully consider who, if anyone, you would like to have access to your medical/account information:

Name/Relationship_____

HIPAA CONSENT OF PRIVACY

I acknowledge that I have been given the opportunity to read and review the Urgent Care Clinic of Lincoln PC's Notice of Privacy Practice. By signing this form I consent to the use and disclosure of protected health information for treatment, payment or healthcare operations.

FINANCIAL POLICY AUTHORIZATION

I have read and agree to the terms and conditions on the financial policy and I hereby authorize the release of any medical information necessary to process my health insurance and request payment of benefits to the provider of services. I understand I am financially responsible to URGENT CARE CLINIC OF LINCOLN for charges not covered or denied by my insurance company.

INSURANCE & ASSIGNMENT OF BENEFITS AUTHORIZATION INFORMATION AND CONSENT TO TREAT

I herby authorize treatment of the above named patient and agree to pay all charges for treatment regardless of insurance coverage or the pendency of insurance claims.

I authorize the release of all medical information to the above insurance carriers that is pertinent to my medical care and necessary to process my insurance claims. I assign all medical and surgical benefits to Urgent Care Clinic of Lincoln PC. A photocopy of this form shall be as valid as the original. I understand that I can withdraw this medical benefit at any time by notifying this office in writing.

By signing below, I agree to all of the policies listed above:

PATIENT SIGNATURE_____ DATE_____

(Parent or Legal Guardian, if minor)

Special Advanced Beneficiary Notice
Coronavirus Testing & Respiratory Panel

Urgent Care Clinic of Lincoln has several ways of testing for coronavirus. Currently the method we prefer is PCR testing because it is the most accurate.

We can send out a specimen which can take 2-4 days to come back depending on lab demand. This test is a single Coronavirus Test that checks only for coronavirus. You may receive a bill from the lab that performed the test and may be responsible for that bill.

We also have an in-house respiratory panel which in addition to approximately 18 different viral strains and 4 bacteria ALSO tests for Covid 19.

Regarding insurance and your financial responsibility to pay for this test, here is what you need to know:

1. We have no way to know which company or policy will approve and/or pay before we run the test. We have in our possession publications from some insurance companies (Blue Cross, Medicare) stating which codes we are to use for testing only to have those companies deny the claims. We have no control over their corporate standards.
2. **Your insurance now considers same day testing elective if you are not sick and have had no exposure.**
3. **If you are requesting either in house or send out Covid 19 testing and have had no exposure and you have no symptoms, you will be required to pay cash for the test as an elective procedure. Despite what your insurance tells you, they will probably deny paying for it.**

So a good way to think about which testing option is to look at it this way. Let's say you buy something big online. You can get free shipping in 2-4 days or you can pay a whole lot extra to get it in 24 hours. The respiratory panel we offer is like that. It is more expensive because it tests 22 targets and you have results in the same day. It is your decision on whether the speed and accuracy of our test is worth the extra cost or whether you wish to do single PCR testing with a send out lab.

What factors in your life, illness, travel, or you just want to know, are your decision to make. In the end, however, ultimately the cost of any medical visit or test is ultimately yours regardless of whether you have insurance and/or how much they choose to pay.

Whether you choose to use the in-house respiratory panel or send out Covid 19 know this:

1. It is a proper test for those who are sick with symptoms especially if exposed to Covid 19.
2. Reimbursement is far more likely (but not guaranteed for reasons stated above) if you are exposed.
3. We will code everything properly matching your needs, complaints, and physical exam to a proper visit and diagnosis even if your insurance company has a different philosophy than ours.
4. If insurance denies payment please call us and we will do everything we can to appeal the claim on your behalf. However, they may not consider this test medically necessary or cost effective under their criteria. In the end if they say no you will need to pay for the test which is billed at $620.00 for in house testing. You will be billed separately by Physician's Lab for the single test.

Therefore:

I (Print Your Name)_____ have read and understand the above regarding coronavirus testing using the in-house respiratory panel and do agree to pay for any costs not covered by my insurance.

Signature_____ Date:_____

_____
Name of Patient Being Seen (If not yourself)

It is important that you understand your rights and responsibilities.

Please read the following carefully.

1. Consent to Contact You

At the Urgent Care Clinic of Lincoln we may need to contact you about test results, appointments, referrals, or billing and insurance information. In an effort to protect your privacy and follow federal guidelines, we have developed the following protocols on leaving medical messages. Unless we have your consent:

- We will not leave messages with anyone except the patient or the legal guardian.
- We will not leave detailed messages on voicemail or answering machines.
- We will not send faxes.
- If your marital status has changed or there are people that you specifically want to include or exclude from access to your records, please let the receptionist know so we can have you fill out a detail sheet.

I hereby understand and give my permission for Urgent Care Clinic of Lincoln to leave phone messages and or fax messages regarding my medical care and account information. I fully understand this consent is en effect and will remain valid until revoked by me in writing.

We have an online patient portal and will be giving you access to your labs and medications. This portal will also allow you to communicate with us in a secure fashion.

2. HIPAA Consent of Privacy

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our policies and procedures pertaining to privacy of information before you sign this consent. We are required to notify you of who may be allowed to view elements of your medical record. This currently includes your insurance company, our collection agency, Lab Corp, Nebraska Lab Link, your primary care physician on request, Advanced Medical Imaging, and the Emergency Department if we send you there. We also have entered an Interoperability Agreement with eClinical Works allowing us to pull patient information from other facilities to help us manage your health. We also request information from area pharmacies to check your medication profile. From time to time we may use personal information to assist us in reaching you through internal marketing campaigns for our benefit only through our contracted SEO agency.

Our policies may change from time to time. If we change our policy, you may obtain a revised copy. You have right to restrict specific elements of your health record. If your restrictions inhibit our ability to provide care or collect reimbursement, we are under no obligation to treat you. If we agree to any additional restrictions you request, we are bound by our agreement. By signing this consent of privacy, you consent to Urgent Care Clinic of Lincoln's use and disclosure of protected health information about you for treatment, payment, or health care operations including disclosure to our business associates as noted above. You have the right to revoke this

consent, in writing, except where we have already made disclosures in reliance on your prior authorization.

Privacy is not just our responsibility, it is also yours. We aim at the highest quality of care and if you have any concerns and issues we ask you attempt to address them privately with us first. If you choose, however, to publicly discuss your care or your experience at our facility verbally, or in writing on any social media or public media forum, you hereby agree to waive ALL rights to your confidentiality. We reserve the right to publish a response using any aspect of your personal or health information to justify the care or experience we have provided to you.

Giving us current demographic information about you and appropriate guarantor information is also your responsibility. If you do not update this information and addresses or guarantor information changes, your personal data may be sent to an inappropriate address. This is not a HIPAA violation as we have your consent on file to send information to the most current information you gave us.

UCCL must obtain specific permission should the practice sell Protected Health Information and gain from such sale. UCCL may sell PHI without authorization where used for medical research and the only renumeration is reasonable cost-based fee to cover the cost to prepare and transmit patient data, and where transmitted for the sale, transfer, merger or consolidation of all or part of the practice and for related due diligence. PHI may be used or disclosed for fundraising and the individual shall have an opportunity to opt-out of future requests. Psychotherapy notes that are used at UCCL no longer require additional authorization to be used or released.

I acknowledge that I have been given the opportunity to read and review the Urgent Care Clinic of Lincoln PC's Notice of Privacy Practice. By signing this form I consent to the use and disclosure of protected health information for treatment, payment, or healthcare operations. I agree to the terms of personally publicly disclosing elements of my care or experience on any personal or social media outlet.

3. Financial Policy and Statement of Responsibility

Thank you for choosing the Urgent Care Clinic of Lincoln, PC. The following is a statement of our Financial Policy. All patients must accept our Financial Policy BEFORE receiving treatment. Full payment of your bill is considered a part of your treatment. While we will assist you in any way we can to obtain payment of benefits from your insurance company, we will not accept responsibility for payment or denial of benefits. Ultimately it is the patient's and/or guardian's responsibility to promptly and fully pay all charges for services and supplies provided by the clinic.

A. Method of Payment: We accept cash, check, visa, and master-card.

B. For Patients with Insurance: As a courtesy to you, we will submit medical claims to your insurance company. Any balance after processing of our claim by your carrier is your responsibility. Your insurance policy is a contract between you and your insurance company. You are responsible for verifying if providers are in-network with your

insurance company. **All co-pays are due prior to treatment.** If you have a high deductible insurance plan, we will collect the full amount at the time of service.

C. Disability and Insurance Forms: There will be a charge of $20 for the completion of medical forms filled out by our providers. Payment for these forms is due before you pick them up. Please allow 7-10 days for the completion of these forms. If you would like the forms mailed to you or your insurance company, payment will be due prior to mailing of the forms.

D. Liability Claims & Auto Accidents: We expect that you will pay for your visit in full at the time of service. We will give what you need to submit the claims to your Auto or Liability Company.

E. Workers Compensation: If your injury is work-related, we will need the case number, carrier name and information prior to your visit in order to bill the worker's compensation insurance company. The patient is ultimately responsible for all professional fees if a worker's compensation claim is denied.

F. Self Payment Accounts: The office visit portion must be paid in full at the time of service. Any ancillary charges are due also in full. We are happy to accept payment by cash, check, credit or debit card. If your remaining balance reaches 45 days past due and you have not made an effort to contact us to make payment arrangements, your account may be turned over to our collection agency. It is your responsibility to make sure we have a proper mailing address so we can reach you in a timely manner.

I have read and agree to the terms and conditions on the financial policy and I hereby authorize the release of any medical information necessary to process my health insurance and request payment of benefits to the provider of services. I understand I am financially responsible to Urgent Care Clinic of Lincoln for charges not covered or denied by my insurance company.

4. Insurance and Assignment of Benefits Authorization information and Consent to Treat

I hereby authorize treatment of the above named patient and agree to pay all charges for treatment regardless of insurance coverage or the pendency of insurance claims. I authorize the release of all medical information to my insurance carriers that is pertinent to my medical care and necessary to process my insurance claims. I assign all medical and surgical benefits to Urgent Care Clinic of Lincoln, PC.

_____ _____

Name of Responsible Party *Date*

_____

Signature