

Patient Information Sheet

Acct No: PATIENT INFORMATION Chart No:
Last, First M. SS#: DOB: Age:
Home Address: Gender: Marital Status: Race:
City: State: Zip: Patient Home Phone:
Patient Work Phone: Patient Cell Phone:
Patient Employer:
Employer Address: Spouse Phone:
City: State: Zip: Spouse Name:

Acct. No: BILLING INFORMATION
Name: Patient's Relationship:
Home Address: SS#: DOB: Gender:
City: State: Zip: Work Phone:
Home Phone: Employer:
Cell Phone: Employer Address:
(if different than patient) City: State: Zip:

EMERGENCY CONTACT INFORMATION

Name/Relationship: Phone:

You must present your insurance card(s) to the receptionist, at each visit, before a claim will be submitted to your insurance. Your bill will be generated by The Physician Network, which is located at 8055 "O" Street, Suite 300, Lincoln, Nebraska, 68510.

PRIMARY INSURANCE INFORMATION

Ins Co Name: Policy Holder Information
Ins Co Address: Name:
City: State: Zip: SS#
Policy #: DOB: Gender:
Group #: Emp Phone:
Effective Date: Emp Name:
Patient's Relationship to Policy Holder:

SECONDARY INSURANCE INFORMATION

Ins Co. Name: Policy Holder Information
Ins Co Address: Name:
City: State: Zip: SS# :
Pat Pol# : DOB: Gender:
Group # : Emp Phone:
Effective Date: Emp Name:
Patient's Relationship to Policy Holder:

I have additional insurance coverage... please give insurance card(s) to Receptionist

Patient's Last Visit Date: Current Account Balance Guarantor is responsible for:

Is this visit due to a: Work-Related injury? YES/NO Motor vehicle Accident? YES/NO Accident? YES/NO

How did the injury occur?

Date of injury:

I have reviewed the information above and made any necessary changes.

Patient/Guarantor Signature: Today's Date:
Checked in By:

NEW PATIENTS ONLY

How did you learn about this clinic? (Please Select One)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Telephone Line to Care, TLC (t) | <input type="checkbox"/> Insurance Company (i) | <input type="checkbox"/> Linc Care (l) | <input type="checkbox"/> Women's Edition (z) |
| <input type="checkbox"/> Phone Book (p) | <input type="checkbox"/> Television (v) | <input type="checkbox"/> Perspectives (q) | <input type="checkbox"/> Movie Theater (b) |
| <input type="checkbox"/> Website (f) | <input type="checkbox"/> Seminar (a) | <input type="checkbox"/> Company Care (c) | <input type="checkbox"/> Mailer (m) |
| <input type="checkbox"/> Existing Patient (e) | <input type="checkbox"/> Southern NE Register (s) | <input type="checkbox"/> Radio (d) | <input type="checkbox"/> Employer (j) |
| <input type="checkbox"/> Word of Mouth (w) | <input type="checkbox"/> Newspaper (n) | <input type="checkbox"/> Physician Referral (r) | <input type="checkbox"/> Emergency Rm (h) |
| <input type="checkbox"/> Other (o) _____ | | | |

Referring Physician: _____

Ethnic Background: (Please select one):

- American Indian (i) Asian (a) Black (b) Caucasian (c) Hispanic (m) Indian (d) Laotian (l)
 Middle East (e) Unknown (u) Vietnamese (v) Other (o)

Do you speak English? Yes / No **If no, what is your primary language?** _____

Smoker? Yes / No

The Physician Network Financial Policy

Welcome to our office. Please read this information about our financial and billing policies. If you do not have insurance, you must pay at the time of service or make other arrangements with our billing staff. We accept cash, personal checks, MasterCard, Visa or Discover Card.

If you have insurance, we will file claims for you. We need your current insurance and policy holder information. You will need to authorize payment directly to us. If your insurance requires co-payments, you must pay that amount at the time of service. You are responsible for paying us for any services not covered by insurance, such as physicals and preventative care.

We will send you a monthly statement so that you know when your insurance company has made a payment and what the remaining balance is. Payment is due upon receipt of the monthly billing statement. Even if you have insurance, **payment to us is your responsibility.**

You should know the details of your insurance plan. Many insurance plans require you to use certain hospitals or doctors and may require pre-certification or referrals to another facility. We are not responsible if you are sent to the wrong facility. You also need to know which doctor or hospital your plan requires you to use.

If your medical care is the result of a work related injury, your claim will be sent to your employer for them to pay directly or to forward to their worker compensation carrier. It is your responsibility to complete any necessary forms to allow us to release information to your employer.

If your medical care is the result of a motor vehicle accident or other liability accident, you will need to let us know at the time of service if the insurance claim should be sent to your private health insurance or if the claim needs to be sent to another insurance carrier.

In the case of a divorce, the custodial parent is responsible for all payments. The Physician Network is not involved in disagreements between the parties in a divorce situation.

You may be billed by other physicians for other services such as lab services or the reading of x-rays.

Accounts not paid in full within 90 days are considered past due. If you cannot make regular payments, please contact us. There is a charge for each returned check and we use a collection agency when necessary. It is your responsibility to contact us to discuss potential eligibility for The Physician Network or other financial assistance programs based on stipulated income requirements or to discuss payment arrangements.

If you have any questions about this information, please call our billing office at (402) 421-0904 or (800) 203-1517.

"I verify the accuracy of the billing information and I authorize the release of any medical information necessary to process my medical claims."

Patient or Authorized Signature: _____ **Relationship:** _____ **Date:** _____