

If no information has changed from your last visit here
Fill in Name and Date of Birth and sign in Patient Signature line
below and on the back

PATIENT INFORMATION

PATIENT Last Name: First: MI:

Address: City: St: Zip:

Home Phone: Cell Phone:

Social Security #: Date of Birth: Gender: M F Marital Status: M S W D

Employer: Phone #:

Address: City: St: Zip

INSURANCE INFORMATION

Insurance Plan Name (copy of card required)

Worker's Comp YES NO

If you are covered by spouse or parent's insurance:
Insured's name

Address:

City: State: Zip:

DOB:

Insured's Employer:

Insured's SS #:

GENERAL INFORMATION

1. List reason for visit:

2. Date & Time of injury/Illness: / / Time: : am/pm

3. Place injury occurred:

4. If an injury, is this Worker's Comp? YES NO How did the injury occur?

How did you hear about us? Word of Mouth Existing Patient Radio TV Other

Do you understand English? Yes No If no, primary language spoken

Emergency Contact (full name) Relationship Phone #

Race: Smoker? Y or N Personal Physician:

MESSAGE AUTHORIZATION FOR ANSWERING MACHINE/VOICE MAIL

Representatives of Saint Elizabeth Physician Network are allowed to leave any and all information regarding my status as a patient on my voice mail or answering machine. I realize this information may include pertinent health status and/or financial information. I hereby authorize Saint Elizabeth Physician Network to communicate to the following people regarding my health status information:

Name: Phone # Relationship

Do not leave a message. (check box if applicable).

Patient Signature Relationship

(Or guardian/guarantor if under the age of 19)

Continued on back ...

Saint Elizabeth
LINC CARE

PARENT/GUARDIAN INFORMATION - REQUIRED TO TREAT A MINOR (under age 19)

Parent/Guardian: _____ Phone #: _____
 Address _____
 (if different than above): _____ City: _____ St: _____ Zip: _____
 Relationship _____
 to patient: _____ Employer: _____ Phone#: _____

Patient Signature _____ **Relationship** _____ **Date** _____
 (Or guardian/guarantor if under the age of 19)

TO BE COMPLETED BY STAFF ONLY - TELEPHONE CONSENT TO TREAT MINOR

Date: _____ Name of Minor: _____ SS #: _____ Date of Birth _____

Name of person giving consent _____ Relationship to minor (must be parent or legal guardian) _____

Consent was given for Linc Care to perform the following procedures: _____

Staff Signature: _____ Date: _____ Staff Signature: _____ Date: _____

SAINT ELIZABETH PHYSICIAN NETWORK (SEPN) FINANCIAL POLICY AND CONSENT TO TREAT

If you do not have insurance, you must pay at the time of service. We accept cash, personal checks, MasterCard, Visa, American Express or Discover. If you have insurance in which we are a provider, we will file claims for you. We need your current insurance and policyholder 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 on 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 precertification 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 compensation carrier. It is your responsibility to complete any necessary forms to allow us to release information to your employer.

In case of divorce, the custodial parent is responsible for all payments. Saint Elizabeth 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 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 of \$25.00 for each returned check and we use a collection agency when necessary. If you have any questions about this information, please call (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. I hereby consent to the rendering of such care, which may include routine diagnostic procedures and medical treatment, as may be considered necessary by the physician(s) and or medical staff charged with the patient's care.

Patient Signature _____ **Relationship** _____ **Date** _____
 (Or guardian/guarantor if under the age of 19)