

Patient Information

Please print-must be updated annually.

Date: _____

Patient Name: _____
 (Full legal name) Last First Middle Initial

Address: _____
 Street Apt/Suite City State Zip

Phone #'s Home: _____ Work: _____ Cell: _____

Patient Employer: _____

Employer Address: _____
 Street Apt/Suite City State Zip

Emergency Contact
 Name: _____ Phone #: _____ Relationship: _____
 (Name and phone number other than self and home)

Patient Social Security #: _____ Birth Date (mm/dd/yyyy): _____ Gender: M F

Marital Status: Married / Single / Widowed / Divorced

Spouse Name: _____ Spouse Phone: _____

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"/> Womens 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"/> Web site (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"/> Other (o) _____ | Name: _____ |

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) Vietnamese (v) Unknown (u)
 Other (o) _____

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

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 providers 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 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 providers 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_____

FOR MEDICARE PATIENTS ONLY

Medicare Secondary – Payer Questionnaire
(To be completed for ALL Medicare patients at each initial visit)

Name _____ Medicare # _____

Is the patient a veteran? _____ Date _____

- 1. Did the VA refer you here for treatment? YES NO
- 2. Does the patient have a VA "Fee Basis ID" card?..... YES NO
- 3. Do you have a "Federal Black Lung" card?..... YES NO
- 4. Is the patient covered by an employer's health insurance plan through their own employment or that of a spouse or other family member? (Not retiree coverage)..... YES NO
- 5. Is your Medicare entitlement based on End Stage Renal Disease?..... YES NO

If you answered "yes" to any of the above questions, please answer the following questions:

- a. Does the patient authorize you to bill the VA?..... YES NO
- b. Are the services you are receiving today related to lung disease?..... YES NO

If the answer is "yes," submit claims to:

*Federal Black Lung Program
P.O. Box 828
Lanham-Seabrook, MD 20703-0828*

- 6. Is this medical condition due to an accident of any kind?..... YES NO
If yes, was it:
Work Related _____ Auto _____ Injured in own home _____ Other _____
- 7. Are the services to be paid for by a Government Research program?..... YES NO

For Medicare Patients Only

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me, or, on my behalf, to The Physician Network for any services furnished to me by their providers. I authorize my holder of medical information about me to release to the Centers for Medicaid and Medicare Services and its agents any information needed to determine these benefits or the benefits payable for related services.

SECONDARY INSURANCE BENEFITS AUTHORIZATION

I hereby authorize payment of my Medigap and/or Secondary Insurance benefits to The Physician Network for all claims filed on my behalf. This authorization applies to all services until it is revoked by me or my representative.

Patient or Authorized Signature _____ Relationship _____ Date _____

For Office Use Only:

Date	Initials of Associate who reviewed questions with the patient	Changes to Questionnaire Yes No	

(additional pages available)