Pine Lake Health, LLC & Waverly Health Care

ADULT HEALTH HISTORY

PATIENT INFORMATION

Full Name: (include middle initial)	Today's Date:
Date of Birth:	Age:
Address 1: :	Social Security #:
Address 2:	Sex:
City:	Language:
State: Zip:	Employer:
Home phone:	Emergency Contact:
Work phone:	Emergency Phone:
Cell phone:	Emergency Relationship:

GUARANTOR INFORMATION (Person whom is financially responsible *if not* the patient.)

Name:	Date of Birth:
Address 1:	Social Security #:
Address 2:	Sex:
City:	Language:
State: Zip:	Employer:
Home phone:	Emergency Contact:
Work phone:	Emergency Phone:
Cell phone:	Emergency Relationship:

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Certificate #:	Certificate #:
Group #:	Group #:
Group Name:	Group Name:
Copay:	Copay:
Subscriber Name:	Subscriber Name:
Social Security #:	Social Security #:
DOB:	DOB:

Authorization to Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Pine Lake Health, LLC, when he/she accepts assignment.

Authorization to Release Medical Information: I hereby authorize my Provider, Pine Lake Health, LLC to release any information necessary for my course of treatment.

_____ _____

Signed (patient, legal guardian or POA) Date

Please fill out the below questionnaire and mark an X where appropriate

Name: _____ Sex: ____M _____ F Today's Date: _____

Age: _____ DOB: _____ Marital Status: ___ S ___ M ___ D ___ W

Employer: _____Occupation:_____

Spouse's Name: _____ Employer & Occupation: _____

Children's Names and Ages: _____
_____

Current Medical Problem: _____
_____

Past or Present (*on going)* Medical Problems: _____
_____

Surgeries & Dates: _____
_____
_____

Immunizations: (*give date of most recent immunization)*
Tetanus_____ Influenza_____ Pneumonia (pneumovax) _____ Shingles(Zostavax)_____

Current Medications:	Dosage:	How Often:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List Any Allergies to Medications and/or Other Substances:
_____Reaction:_____
_____Reaction:_____

Family History: (*Indicate maternal or paternal relatives with any of the following problems)*
Heart Disease: _____
High Blood Pressure: _____
Diabetes: _____
Cancer: (Include type) _____
Other Inherited Diseases: _____
Emotional Problems: _____

Health Habits: **(*Mark with X in the appropriate place below)***
Tobacco Use: _____Never _____In The Past _____Now
Type of tobacco: _____ How Much: _____ How Long: _____
Alcohol: _____Never _____Rarely _____Frequently | How Much: _____
Street Drugs: _____Never _____Rarely _____Frequently | What: _____
Exercise: _____Never _____Rarely _____Frequently | How Often: _____
Seatbelt: _____Never _____Sometimes _____Always
Eating: _____Poorly _____Meets Needs _____Excessively
Caffeine: _____Never _____Sometimes _____ Frequently | How Much:_____

Approximate number of hours of sleep per night? : _____

Colonoscopy Date: _____ Mammogram Date: _____

Name: _____Today's Date: _____

Have you had any of the following problems: (Include current and past problems) **Mark with X in the appropriate column**

General	**Current**	**Past**
Weight Gain	_____	_____
Weight Loss	_____	_____
Appetite Loss	_____	_____
Chills/Fever	_____	_____
Fatigue	_____	_____
Sleep Difficulties	_____	_____
Lymph Gland Swelling/Lumps	_____	_____

HEENT	**Current**	**Past**
Frequent Headaches	_____	_____
Recent Changes in vision	_____	_____
Glaucoma	_____	_____
Cataract	_____	_____
Hearing Loss	_____	_____
Ringing in the Ears	_____	_____
Frequent Nosebleeds	_____	_____
Persistent Hoarseness	_____	_____
Difficulty Swallowing	_____	_____
Sore Throat	_____	_____

Respiratory	**Current**	**Past**
Frequent cough	_____	_____
Snoring	_____	_____
Asthma	_____	_____
Emphysema	_____	_____
Shortness of Breath	_____	_____
Coughing up Blood	_____	_____
Coughing up Phlegm	_____	_____
Tuberculosis	_____	_____
Recurrent Pneumonia	_____	_____
Recurrent Bronchitis	_____	_____

Genitourinary	**Current**	**Past**
Blood in Urine	_____	_____
Difficulty Starting Urine	_____	_____
Burning with Urination	_____	_____
Urinary Frequency	_____	_____
Urinary Incontinence	_____	_____
Slow Urine Flow	_____	_____
Bladder Infections	_____	_____
Kidney Infections	_____	_____
Kidney Stones	_____	_____
Venereal Disease	_____	_____
Men		
Prostate Problems	_____	_____
Discharge from Penis	_____	_____
Lump in Testicles	_____	_____
Women		
Vaginal Discharge	_____	_____
Irregular Periods	_____	_____
Painful Periods	_____	_____
Pain with intercourse	_____	_____
Abnormal Vaginal Bleeding	_____	_____
Abnormal PAP Test	_____	_____

Date of last PAP _____/_____/_____
Age of Onset of Periods: _____
Total # of days in Cycle: _____Days of Flow: _____
Number of Pregnancies_____ Number of Children_____
Method of Birth Control: _____

Endocrine	**Current**	**Past**
Thyroid problems	_____	_____
Excessive thirst or urination	_____	_____
Diabetes/High Blood Sugar	_____	_____

Skin	**Current**	**Past**
Excessive Sweating	_____	_____
Rash	_____	_____

Neck	**Current**	**Past**
Neck Pain	_____	_____
Neck Stiffness	_____	_____

Breast	**Current**	**Past**
Breast Pain	_____	_____
Nipple Discharge	_____	_____
Breast Lump	_____	_____

Cardiovascular		
Chest Pain	_____	_____
Severe calf pain when walking	_____	_____
Shortness of Breath with exercise	_____	_____
Irregular Heartbeat	_____	_____
High Blood Pressure	_____	_____
Palpitations/Heart Racing	_____	_____
Waking at night due to	_____	_____
Shortness of Breath	_____	_____
Heart Attack	_____	_____
History of Heart Failure	_____	_____
Rheumatic Fever	_____	_____
Heart Murmur	_____	_____

Gastrointestinal	**Current**	**Past**
Hemorrhoids	_____	_____
Frequent Abdominal Pain	_____	_____
Black Tarry Stools	_____	_____
Recent Change in Bowel Habits	_____	_____
Constipation	_____	_____
Diarrhea	_____	_____
Vomiting Blood	_____	_____
Indigestion/Heartburn	_____	_____
Nausea	_____	_____
Rectal Bleeding/Bloody Stool	_____	_____
Vomiting	_____	_____
Hepatitis/Liver Problems	_____	_____
Gallbladder Problems	_____	_____
Ulcers	_____	_____

Musculoskeletal	**Current**	**Past**
Painful/Swollen Joints	_____	_____
Persistent Back or Neck Pain	_____	_____
Decreased Range of Motion	_____	_____
Muscle Pain	_____	_____

Neurological	**Current**	**Past**
Numbness in Face, Arms, Legs	_____	_____
Fainting/Loss of Consciousness	_____	_____
Seizures or Epilepsy	_____	_____
Previous Stroke	_____	_____
Weakness in Face, Arms, Legs	_____	_____

Psychological	**Current**	**Past**
Frequent Anxiety	_____	_____
Depression	_____	_____
Loss of Interest in Usual Activities	_____	_____
Recent Thoughts of Suicide	_____	_____
Suicide Attempt	_____	_____

Hematology	**Current**	**Past**
Abnormal Bleeding	_____	_____
Anemia	_____	_____
Blood Clots	_____	_____

Pine Lake Health, LLC & Waverly Health Care

2611 S. 70th St. Lincoln, NE 68506

HIPAA RELEASE OF INFORMATION

(Please Print)

Patient Name: _____ **DOB**: _____

Receipt of Notice of Privacy Practice

_____ I have been offered or received a copy of Pine Lake Health, LLC's Notice of Privacy Practices.
Initial

Message Authorization

Representatives of Pine Lake Health, LLC are allowed to leave any and all information regarding my status as a patient on my voice mail, answering machine, or email. I realize this information may include pertinent health status and/or financial information.

□ DO NOT leave a message *(Check box if applicable)*

Authorization to Communicate Personal Health Information:

Pine Lake Health, LLC may communicate information to the following people regarding my health status as needed:

Name _____Phone Number _____ Relationship _____

Name _____Phone Number _____ Relationship _____

_____
Patient Authorized Signature

_____
Relationship to patient Date

For MEDICARE Patients ONLY

MEDICARE Authorization

I request that payment of authorized MEDICARE benefits be made either to me, or, on my behalf, to Pine Lake Health, LLC for any services furnished to me by its physician. I authorize my holder of medical information 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 Pine Lake Health, LLC for all claims filed on my behalf. This authorization applies to all services until my representative or I revoke it.

_____
Patient Authorized Signature

_____
Relationship to patient Date

Pine Lake Health, LLC & Waverly Health Care

2611 S. 70th St. Lincoln, NE 68506

FINANCIAL POLICY AND PATIENT RESPONSIBILITIES

Thank you for choosing Pine Lake Health, LLC as your primary health care provider. We are committed to assisting you with timely insurance filing and payment of your account. The following is a statement of our Financial Policy, which we require you to read and sign prior to initial visit.

Pine Lake Health, LLC is committed to providing the best treatment possible for our patients. Patients are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Our practice participates with many insurance plans and a current listing is available at each location and on our website www.pinelakehealth.com. If your insurance plan does not cover our services, payment in full is expected at the time of your visit. We accept cash, checks, MasterCard, Visa, Discover, and debit cards.

Updated insurance information must be given to us at the time of service. We will require a copy of your insurance cards before services are performed and these will be scanned into our system. We file all insurance claims in a timely manner. After filing, we allow 30 business days for your insurance company to pay. If your insurance company fails to make payment, you will be responsible for payment in full.

If the patient is a minor, the adult accompanying the child for treatment will ultimately be responsible for payment. We cannot become involved in third party liabilities, personal injury, or custody issues to determine the responsible party for payment. We cannot accept an attorney's letter of payment guarantee If you have a past due personal balance on your account, you will need to contact the billing office to make payment arrangements prior to receiving most services. Any account that is over 90 days past due will be sent to an independent collection service and may be subject to reporting to the credit bureau and possible termination of the doctor/patient relationship.

Copays, Co-insurance and /or Deductibles – There may be some copay, co-insurance or deductible charges associated with certain medical services and tests. Patient payment of the copay, co-insurance, or deductible is required at the time of service.
Pre-certification – Pre-certification or prior approval may be required by your health plan before certain procedures, tests, or surgeries are performed. We will assist you in the pre-certification process by contacting your insurance company on your behalf. It is your responsibility to confirm that you have been granted approval of certification before your appointment so you do not incur any unnecessary personal charges.

Other physician charges – Our practice is committed to providing the best treatment for our patients which may necessitate the outsourcing of some services to other professionals. When this occurs, you may receive a statement from the provider of ancillary services such as Pathology, Laboratory, and/or Radiology interpretation services, unless Pine Lake Health, LLC purchased these services.

Motor Vehicle Accident – Medical insurance will be filed and any co pay, co-insurance or deductible is required to be paid at the time of service. If no payment is received from the insurance company after 30 business days, it will become the patient's responsibility. Filing claims to the auto insurance is the responsibility of the patient.

Unless contractually prohibited by your insurance carrier, you may be personally charged the following additional fees. These fees will not be filed to your insurance carrier and are the direct responsibility of the patient. Please initial to the left of each category to indicate your acknowledgement.

_____ ***No Show Appointments & Returned Checks. –*** Unless canceled at least 24 hours in advance,
(INITIAL) depending on the type of appointment, you may be charged a fee of $25.00 to $50.00 for each occurrence. After the 2nd no show appointment you will be dismissed from the practice. All returned checks will be charged a fee of $25.00 for each occurrence.

_____ ***Patient Billing Fee*** – Unless other suitable arrangements are made in advance, patients who fail to pay their co-payment,
(INITIAL) co-insurance, deductible, or estimated balance due at the time of service may be billed a fee up to $25.00 for each occurrence. I agreed to be billed a fee of 35% of a bad debt balance for any extraordinary costs associated with collection of funds owed to Pine Lake Health, including but not limited to, collection agency fees, attorneys' fees and court costs.

_____ ***Forms / Letters / Copy of Medical Records –*** There is a charge for completion of all forms, letters, or copying of medical records.
(INITIAL) Payment must be made before the completion or release of any forms, letters, or medical records.
Forms for disability, FMLA and etc. could range from $50-$300 per occurrence depending on the complexity of the requested paperwork plus the patient visit. Copying of medical records is charged $.50 cents per page. Copying of medical records (PDF) to CD is charged at $30 per patient.

I certify that the information given by me in applying for payment under my insurance contract is correct. I authorize any holder of medical or other information about me to release to any third party payers (including Medicare and Medicaid) information needed for claims for health care benefits. I request that payment of authorized health care benefits be paid and I assign the benefits payable for the physician services to the physician or organization furnishing the services. I authorize such physician or organization to submit a claim to my health insurance carrier or any other third party payer, including Medicare and Medicaid, on my behalf. I request payment of benefits under Title XVIII (Medicare and XIX Medicaid) of the Social Security Act to Pine Lake Health, LLC. I understand that I am financially responsible for charges not covered by the assignment, and I hereby guarantee timely payment in full of any such charges.

By signing below, I acknowledge that I have read and fully understand this Policy and my financial responsibilities as a patient of Pine Lake Health, LLC.

Print Patient Name: _____Date _____

Signature of Patient or Responsible Party _____

Pine Lake Health, LLC & Waverly Health Care

2611 S. 70th St, Lincoln NE 68506 | Phone: (402) 423-4200 | Fax: (402) 423-4201 | Email: info@pinelakehealth.com

Authorization for the Release of Medical Information / Medical Records

Patient Name: _____ Date of Birth: ____/_____/_____
Last First MI

TO or FROM (circle one) :	**TO:**
_____ **(Name of facility or Medical Provider)**	**Pine Lake Health / Waverly Health Care**
_____ **(Address)**	2611 S. 70th St, Lincoln NE 68506 OR 13220 Callum Dr. Suite 4, Waverly NE 68462 (**do not send records to the Waverly address**)
_____ **(Address)**	**Fax: 402-423-4201**
_____ **(Phone & Fax)**	(*Please DO NOT fax more than 10 pages! Records over 10 pages, please send via secure email or place on CD & mail to our address*)

Please send the following health information:

____ Entire Medical Records ____ Inclusive Dates Only ___/___/_____-___/___/_____

____ Immunization Records ____School Physicals ____ Mental Health Records

____ Other; if applicable, the following health information related to testing, diagnosis, and or treatment for:

_____ HIV/AIDS virus _____sexually transmitted disease _____mental health _____ drug and/or alcohol abuse.

Information to omit: State and Federal law protect the following information as directed by you, the patient.

____ Mental Health records ____HIV/AIDS records ____Substance abuse (Drugs/Alcohol) records

____Other:_____

If leaving practice, please provide us with the following (check all that apply):

____Referral to/from another medical office ____Moving/Moved ____Legal Purposes
____Insurance Purposes ____Personal ____Other:_____
____Transfer to new physician; reason_____

The date of this authorization is _____ / _____ / _____ and shall remain in effect until _____ /_____ / _____
(if no ending date is given, it shall remain in effect for one year from the date of authorization).

Conditions: We may not condition your right to receive health care services from us upon your signing of this authorization if you are leaving our practice. However, if the treatment to be provided is for research purposes, your failure to sign this authorization will prevent us from providing such treatment.

Further use and disclosures: When we use or disclose your health information to other parties as you have instructed in this authorization, we will not have the ability to monitor whether your health information may be further used or disclosed by such parties. In such situation, your disclosed health information may no longer be protected by federal and state laws.

Revocation: You have the right to revoke this authorization at any time by notifying the providing organization in writing.
When we receive your revocation, we will immediately stop using or disclosing the health information you authorized us to use and disclose in this authorization form. Your revocation shall not apply to those uses and disclosures we made on your behalf pursuant to this authorization prior to the time we received your written revocation.

Reimbursement: Pine Lake Health, LLC reserves the right to recover the cost involved in producing the requested health information. You or the party to receive disclosures, named able, may be charges $20.00 plus 50 cents per page for handling and coping this information.

I authorize the use and disclosure of the medical records and health care information indicated above:

Print Name: _____ Date: ____/ ____ / _____

Patient Signature: _____

Relationship to patient: self or _____