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:	**Email Address:**
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

Name: _____ Sex: ☐ M ☐ F Today's Date: _____

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

Do you have a PCP (Primary Care Provider? If so, who? _____
Are you transferring all of your medical care to this clinic? ☐ Yes / ☐ No

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 DISCLOSURE

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The notice contains a Patient Rights section describing your rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You have the right to review our Notice before signing this Consent. The terms of our notice may change at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to; Privacy Officer, Pine Lake Health, 2611 S 70th St, Lincoln, NE, 68506.

PATIENT CONSENT FOR DISCLOSURE OF PROTEXTED HEALTH INFORMATION TO INSURANCE

I request that payment under medical insurance programs/Medicare, be made to Pine Lake Health, LLC. I authorize Pine Lake Health to release information necessary to aid in processing and payment of charges. If Medicare applies to me, I authorize Pine Lake Health, LLC to release information to the Social Security Administration or its intermediaries or carriers. I understand that my insurance coverage is a contract between me and my insurance carriers and I am ultimately responsible for the charges of the services provided to me.

PATIENT COMMUNICATION

I hereby grant my healthcare provider permission to contact me via an automated phone/text/email system. I authorize my healthcare provider to disclosure to third parties who answer my phone or have access to my communications my limited protected health information, and to leave a message on these devices.

X_____/_____/_____
Signature of Patient/Responsible Party **Printed Name of Patient** **D.O.B**

Mailing Address _____Apt # _____

City_____ **State**_____ **Zip Code** _____

Primary Phone #_____ **Patient Email** _____

Patient (Guarantor's) Employer Name & Phone Number:_____

MESSAGE AUTHORIZATION

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

☐ DO NOT text me appointment reminders *(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 _____

I acknowledge it is my responsibility to supply accurate insurance information to Pine Lake Health or I will be responsible for all charges. If my insurance does not have a network contract with Pine Lake Health, I understand I will be billed at Pine Lake Health's out of network rate. I also understand if a service is preformed that is deemed non-covered, I will be responsible for the full non-covered rate. I agree to pay the out of network/non-covered rate.

Initial Here _____ **Today's 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.

_____ (INITIAL) ***No Show Appointments & Returned Checks. –*** Unless canceled at least 24 hours in advance, 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.

_____ (INITIAL) ***Patient Billing Fee*** – Unless other suitable arrangements are made in advance, patients who fail to pay their co-payment, 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.

_____ (INITIAL) ***Forms / Letters / Copy of Medical Records –*** There is a charge for completion of all forms, letters, or copying of medical records. 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:** _____/_____/_____

TO or FROM (check one) :	**Pine Lake Health / Waverly Health Care**
_____ **(Name of facility or Medical Provider)**	2611 S. 70th St, Lincoln NE 68506
_____ **(Address)**	(**do not send records to the Waverly address**)
_____ **(Address)**	**Fax: 402-423-4201**
_____ **(Phone & Fax)**	**Email: info@pinelakehealth.com**

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 ?) _____