Midlands Healthcare Group

611 West Francis St. Ste 100
North Platte, Ne 69101
Phone: 308-534-2532
Fax: 308-534-6615
www.midlandshealthcare.com

Midlands Family Medicine
Midlands Occupational Medicine
Midlands Internal Medicine
Family Medical Center

PATIENT INFORMATION FORM

Name: _____ ☐ Male ☐ Female
FIRST MIDDLE LAST

Social Security # : _____ Date of Birth: _____

Home Address: _____ City:_____ ST:____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ Email: _____

Spouse's Name: _____Cell Phone:_____

Spouse's Date of Birth: _____ Spouse's Social Security # : _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African-American ☐ More Than One Race ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Refused to Report/Unreported

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refused to Report/Unreported

Language: ☐ English ☐ Spanish ☐ Other_____

Emergency Contact:

Name/Relationship:_____ Phone Number:_____

Nearest Relative not living with you: _____ Phone Number: _____

Insurance Information:

Policy Subcriber/Guaranter:_____ _____

Employer: _____ Employer Address:_____

Current Health Insurance : _____ ID # : _____

Ins Claim Mailing Address : _____

Social Security #_____

Insured Policy Holder: _____Date of Birth: _____

(We will need to copy your photo ID, insurance card-please bring with you to each visit)

Who is responsible for this bill? _____

I will be paying today by: ☐cash ☐check ☐credit card

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have completed the above questions and read this statement. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____
Signature Date

_____ _____
Parent (if minor) Date

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Please read below pertaining to Midlands Healthcare Group Policies and Consent to Treat

PATIENT NAME – (Print legibly) _____ DATE OF BIRTH _____

- *As a patient paying for today's office visit (**SELF PAY PATIENTS**), I understand that **payment of cash or credit card is due at time of service.***
- I have insurance and have provided that information to Midlands Healthcare Group. I realize that it is ***my responsibility*** to notify Midlands Healthcare Group of any insurance or address changes.
- I understand that ***co-pays are due at the time of service*** and that this is a contract between me and my insurance company.
- I understand that some services recommended by Midlands Healthcare Group may or may not be covered by my insurance company and that ***non-covered services are still my responsibility. Failure to provide accurate insurance information will result in all charges being assigned directly to patient/guardian.***
- I understand that the estimate of benefits by my insurance is not a guarantee of payment and may not be accurate at the time of my visit. I will be responsible to pay for those procedures not covered by my policy. It is the patient/guardian responsibility to know what their benefits are.
- I understand that after **90 days from date of service if my insurance company has not made a payment on my claim it will be my responsibility to pay Midlands Healthcare Group and follow up with my insurance company.**
- I understand that a ***$20.00 fee will be added for all returned checks.***
- Of late we've had patients request medical services for themselves (refills, evaluation, opinions) while accompanying their loved one(s) during their appointment. ***While minimal commentary from the physician may be appropriate and deemed "pro bono" (i.e.—Tylenol dosing), I understand that, at the discretion of the Midlands's Family Medicine provider, I may be billed for an appointment while requesting the aforementioned services. I understand, too, however, that while accompanying a loved one to an appointment I may request an appointment for myself at the front desk and oftentimes be accommodated for such a request.***
- **My signature** below indicates that I have been given or offered and understand the Payment, Insurance, and General Policy's of Midlands Healthcare Group**.**
- By signing this form, I voluntarily consent to receive medical treatment from the medical staff and nursing team at Midlands Healthcare Group. Medical treatment may include, but are not limited to, interview, examination, tests and procedures deemed appropriate by the treating provider.

  Permission for evaluation and treatment is also granted if the above named patient is a minor, whether accompanied by the parent, other family member, unrelated person or unaccompanied.

_____ _____

SIGNATURE (Patient or Legal Custodian/Authorized Representative) Date

Relationship to Patient if signed by another party:_____

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Notice of Privacy Practices and Patient Consent
For use and Disclosure of Protected Health Information

PATIENT NAME—(Print legibly) DATE OF BIRTH

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand the Midlands Healthcare Group may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Midlands Healthcare Group has a detailed document called the **'Notice of Privacy Practices'**. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the "Notice" before signing this agreement. If I ask, Midlands Healthcare Group will provide me with the most current Notice of Privacy Practices.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Midlands Healthcare Group to use and disclose my protected health information to carry out treatment, payment, and health care operations, including but not limited to HIE(health information exchange), data sharing. I have the right to revoke this consent in writing at any time, except to the extent that Midlands Healthcare Group has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) DATE

Relationship to Patient if signed by another party

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our 'Notice' at any time by contacting: Midlands Healthcare Group.

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practice from this patient but it could not be obtained because:

___ The patient refused to sign
___ Due to an emergency situation it was not possible to obtain an acknowledgement.
___ We weren't able to communicate with the patient
___ Other (Please provide specific details)

EMPLOYEE SIGNATURE DATE

Last updated 12/27/2016

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_____ _____

PATIENT NAME—(Print legibly) DATE OF BIRTH

May we leave messages regarding test results and appointments? _____ ☐ Yes _____ ☐ No

We cannot discuss your Protected Health Information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below name(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

Name: _____ Relationship: _____ Phone Number: _____
Date of Birth: _____

Name: _____ Relationship: _____ Phone Number: _____
Date of Birth: _____

Name: _____ Relationship: _____ Phone Number: _____
Date of Birth: _____

Name: _____ Relationship: _____ Phone Number: _____
Date of Birth: _____

Name: _____ Relationship: _____ Phone Number: _____
Date of Birth: _____

_____ _____

SIGNATURE (Patient or Legal Custodian/Authorized Representative) DATE

_____

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