

Auburn Family Health Center, P.C.

Gary R. Ensz, MD

John A. Gill, MD

Michael L. Zaruba, MD, FAAFP

Andrew C. Ensz, MD

Amanda L. Ensz, MD

Madhav P. Narayan, MD

Lindsey H. Adams, PA-C

Daniela P. Lagunas, PA-C

WELCOME! Thank you for selecting our healthcare team! To help us meet all your health care needs, please fill out this form completely.
If you have any questions or need assistance, please ask us – we will be happy to help!

PATIENT INFORMATION

Patient Name: _____

Home Phone: _____

Address: _____

Cell Phone: _____

City, ST Zip _____

Date of Birth: _____

Language: English Spanish Other Refuse

Gender: _____

Race: White Black American Indian

Social Security #: _____

Hispanic Other Refuse

Email: _____

Ethnicity: Not Hispanic or Latino Hispanic or Latino Refuse

Marital Status: _____

Employer: _____

Spouse's Name: _____
(if applicable)

Work Phone: _____

PHARMACY: _____

Preferred Provider: Ensz Gill Andrew Narayan Amanda
(Please circle) Lindsey Daniela

MEMBERS IN HOUSEHOLD ON PATIENT ACCOUNT

<u>Name:</u>	<u>Birthdate:</u>	<u>Name:</u>	<u>Birthdate:</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EMERGENCY CONTACT

Name: _____ Home Phone: _____
How Related: _____ Cell Phone: _____
Work Phone: _____

HEAD OF HOUSEHOLD / RESPONSIBLE PARTY

Patient Name: _____ Home Phone: _____
Address: _____ Cell Phone: _____
City, ST Zip _____
Date of Birth: _____ Employer: _____
Work Phone: _____

INSURANCE

Primary : _____ Secondary: _____
Subscriber: _____ Subscriber: _____
Date of Birth: _____ Date of Birth: _____
Policy #: _____ Policy #: _____
Group #: _____ Group #: _____

I hereby authorize Auburn Family Health Center, P.C. to release any medical or incidental information that may be necessary for either medical care or other information necessary to process claims for financial benefit. I request that payment of surgical and/or medical benefits be made to Auburn Family Health Center, P.C. from my insurance carriers.

**I understand that I am responsible for my insurance copay at the time of service and any balance due. **

Signature: _____

Date: _____

Acknowledgment of Receipt
Notice of Privacy Practices

Auburn Family Health Center, P.C.
2115 14th Street, Suite 100
Auburn, Nebraska 68305

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information and outlining my health information rights.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

Patient Name (Please Print): _____

Patient Date of Birth: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Assignment and Instructions for Direct Payment to Health Provider

I hereby instruct your insurance company/companies to pay by check made out to and mailed directly to: AFHC for professional/medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the mentioned assignee and I agree to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment as required by my insurance policy. I understand that: AFHC is compliant with HIPAA and will protect my *Protected Health Information* (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case to any insurance, adjuster or attorney for the purpose of securing payment under this insurance policy or to any medical provider associated with my case to effectively treat me, following HIPAA guidelines. The authorization is in effect until 90 days from the date the last bill is collected.

By signing below, I provide consent for: AFHC and its providers to e-prescribe my medications and to download my medication history from an online pharmacy clearinghouse for treatment purposes.

A photocopy of this Assignment shall be considered effective and valid as the original.

Patient Name (Print): _____

Date of Birth: _____

Patient Signature

Date Signed

Parent or Guardian Signature

Date Signed

Staff Witness Signature

Date Signed

AUBURN FAMILY HEALTH CENTER, P.C.

FINANCIAL POLICY

(effective November 2019)

Thank you for choosing Auburn Family Health Center, P.C. for your medical care. Our physicians and staff are committed to providing you with the best possible care.

Our fees for services are based on the level of professional skill required; the severity and complexity of the injury or illness, as well as the time spent treating you. The medical services you seek imply financial responsibility on your part. This responsibility obligates you, the patient or responsible party, for payment in full for the services you receive. Your clear understanding of our Financial Policy is important to our professional relationship. To assist in understanding that financial responsibility, we ask that you read and sign this form. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries your insurance, please share this policy with them, as it explains our practices regarding insurance billing, copayments, and patient billing.

REGISTRATION: You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance and paying any co-pays or other patient responsibility amount at each visit. It is your responsibility to provide our office with any demographic changes that may occur over time.

INSURANCE: Billing of insurance is a courtesy we provide our patients. It is your obligation to keep our office updated on your insurance coverage. The patient is ultimately responsible for payment for any charges incurred. If you do not present your insurance card within 60 days from your visit, you will be responsible for the billed amount. Once again, please notify AFHC if your insurance carrier or policy has changed.

PROOF OF INSURANCE: Please bring your insurance card(s) with you to each appointment. It is your responsibility to inform the receptionist when you check in for your appointment when the cause of treatment may be the responsibility of a third party – auto insurance, liability insurance company, worker's compensation – instead of your regular health insurance carrier. Should either insurance company reimburse you directly, we expect immediate payment from you in full.

SELF-PAY PATIENTS: All self-pay patients and patients who present without proof of insurance are required to pay their bills for their services. Payment plans may be arranged through the Billing Department. For new patients with no insurance, a deposit of \$135 is required on the day of the appointment before being seen by the physician. Any fees remaining will be collected following your appointment.

COPAYMENTS: Your insurance REQUIRES that we collect your designated co-pay at the time of service! Please be prepared to pay the co-pay at each visit, it is YOUR obligation to the insurance company. If you fail to pay the co-pay, you may be asked to reschedule your appointment. Chronic non-payment can constitute severance from our practice.

NON-PARTICIPATING INSURANCE PLANS OR "OUT OF NETWORK": You are responsible for care not covered by your out-of-network insurance plan. Patients treated by any physician at AFHC who does not participate in your insurance plan, are directly responsible for the charges which may not be reimbursed by insurance. Please be aware that we are unable to participate with CHI plans.

WORKER'S COMPENSATION: For Worker's Compensation claims, it is our policy to bill your employer or the worker's compensation carrier for services rendered. It is your responsibility to contact us with the name, address, and phone number of your employer or the insurance company, which covers your employer. If you are covered, we will accept the payment made by worker's compensation as payment in full. If worker's compensation denies payment, the entire balance will become your responsibility.

DIVORCE AND CHILD CUSTODY CASES: In the case of divorce or separation, the parent authorizing treatment for a child/children will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect reimbursement from the other parent. We do not get involved in divorce situations and the parent who brings the child to the office for medical treatment is responsible for payment.

COLLECTIONS: All balances are due in full upon receipt of this statement. If you cannot pay the balance in full, please contact our Patient Accounts Specialist to make arrangements. Easy pay consent is strongly encouraged. You will receive two monthly statements. If the account still has not received a payment on it, then it will be placed into our collection cycle. If there has been no attempt of making a payment on your account within 90 days, the account may be forwarded to a collection agency. Please understand, we do not handle the accounts from this point forward.

THIRD PARTY INSURANCE FORMS (DISABILITY, FMLA, ETC) AND MEDICAL RECORDS: There is a charge for completing any form that is not directly related to reimbursement of medical services. Fees are determined by the type of form that is being completed. Charges for copying and sending medical records may apply. These services must be paid in full prior to completion.

PAYMENT OPTIONS: Acceptable payment methods are: cash, check, debit card, and credit card (Mastercard, Visa, Discover, and American Express). We offer an automatic withdrawal by debit card from your bank account called Easy Pay Consent. You specify the amount and the time of the month for the withdrawal. This has been proven to be an "easy" and consistent way to make payments on your account.

PRIOR AUTHORIZATIONS: Please notify our office if your insurance plan requires prior authorization prior to your appointment and/or procedure. As we will try our best to obtain these prior authorizations, it is ultimately your responsibility to verify with your insurance company to ensure appropriate payment.

ACKNOWLEDGEMENT: I have read and understand AFHC Financial Policies and agree to comply with the policies. In addition, AFHC has my permission to provide medical documentation in order to obtain reimbursement.

**I HAVE READ AND UNDERSTAND
AUBURN FAMILY HEALTH CENTER, P.C.'S FINANCIAL POLICY:**

Signature of Person Financially Responsible for Bill

Date

HEALTH HISTORY

Welcome to our practice! As a new patient, please fill out the information below to the best of your ability.

Date: _____
 Birthdate: _____

Patient Name: _____

Reason for today's visit: _____

History of present illness: _____

Previous Physician/Office: _____ City/State: _____

Past Medical History

Have you ever had the following: (Check 'no' or 'yes', leave blank if uncertain)

Measles <input type="checkbox"/> No <input type="checkbox"/> Yes	Anemia <input type="checkbox"/> No <input type="checkbox"/> Yes	Back Pain <input type="checkbox"/> No <input type="checkbox"/> Yes	Hepatitis <input type="checkbox"/> No <input type="checkbox"/> Yes
Mumps <input type="checkbox"/> No <input type="checkbox"/> Yes	Bladder Infections <input type="checkbox"/> No <input type="checkbox"/> Yes	High Blood Pressure <input type="checkbox"/> No <input type="checkbox"/> Yes	Ulcer <input type="checkbox"/> No <input type="checkbox"/> Yes
Chickenpox <input type="checkbox"/> No <input type="checkbox"/> Yes	Epilepsy <input type="checkbox"/> No <input type="checkbox"/> Yes	Low Blood Pressure <input type="checkbox"/> No <input type="checkbox"/> Yes	Kidney Disease <input type="checkbox"/> No <input type="checkbox"/> Yes
Whooping Cough <input type="checkbox"/> No <input type="checkbox"/> Yes	Migraine Headaches <input type="checkbox"/> No <input type="checkbox"/> Yes	Hemorrhoids <input type="checkbox"/> No <input type="checkbox"/> Yes	Thyroid Disease <input type="checkbox"/> No <input type="checkbox"/> Yes
Scarlet Fever <input type="checkbox"/> No <input type="checkbox"/> Yes	Tuberculosis <input type="checkbox"/> No <input type="checkbox"/> Yes	Date of Last Chest X-ray: _____	Bleeding Tendency <input type="checkbox"/> No <input type="checkbox"/> Yes
Diphtheria <input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes	Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes	Any other disease <input type="checkbox"/> No <input type="checkbox"/> Yes
Smallpox <input type="checkbox"/> No <input type="checkbox"/> Yes	Cancer <input type="checkbox"/> No <input type="checkbox"/> Yes	Hives or Eczema <input type="checkbox"/> No <input type="checkbox"/> Yes	Please List: _____
Pneumonia <input type="checkbox"/> No <input type="checkbox"/> Yes	Polio <input type="checkbox"/> No <input type="checkbox"/> Yes	AIDS or HIV + <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Rheumatic Fever <input type="checkbox"/> No <input type="checkbox"/> Yes	Glaucoma <input type="checkbox"/> No <input type="checkbox"/> Yes	Infectious Mono <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Heart Disease <input type="checkbox"/> No <input type="checkbox"/> Yes	Hernia <input type="checkbox"/> No <input type="checkbox"/> Yes	Bronchitis <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Arthritis <input type="checkbox"/> No <input type="checkbox"/> Yes	Blood or Plasma Transfusions <input type="checkbox"/> No <input type="checkbox"/> Yes	Mitral Valve Prolapse <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Venereal Disease <input type="checkbox"/> No <input type="checkbox"/> Yes		Stroke <input type="checkbox"/> No <input type="checkbox"/> Yes	_____

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
<input type="checkbox"/> None _____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: (Include nonprescription) None _____

Past Social History:

Marital Status: Single Married Separated Divorced Widowed

Use of Alcohol: Never Rarely Moderate Daily

Use of Tobacco: Never Previously, but quit _____ Current type/use per day: _____

Use of Drugs: Never Type/Frequency _____

Excessive Exposure at home or work to: Fumes Dust Solvents Air-borne Particles Noise

Family Medical History:

	Age:	Diseases:	If Deceased, Cause of Death:
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____
_____	_____	_____	_____
Children:	_____	_____	_____
_____	_____	_____	_____

Please continue on next page....

Review of Systems: Please indicate any personal history below:

Constitutional Symptoms		Genitourinary		Psychiatric	
Good general health lately	<input type="checkbox"/> No <input type="checkbox"/> Yes	Frequent urination	<input type="checkbox"/> No <input type="checkbox"/> Yes	Memory loss or confusion	<input type="checkbox"/> No <input type="checkbox"/> Yes
Recent weight change	<input type="checkbox"/> No <input type="checkbox"/> Yes	Burning or painful urination	<input type="checkbox"/> No <input type="checkbox"/> Yes	Nervousness	<input type="checkbox"/> No <input type="checkbox"/> Yes
Fever	<input type="checkbox"/> No <input type="checkbox"/> Yes	Blood in urine	<input type="checkbox"/> No <input type="checkbox"/> Yes	Depression	<input type="checkbox"/> No <input type="checkbox"/> Yes
Fatigue	<input type="checkbox"/> No <input type="checkbox"/> Yes	Straining while urinating	<input type="checkbox"/> No <input type="checkbox"/> Yes	Insomnia	<input type="checkbox"/> No <input type="checkbox"/> Yes
Headaches	<input type="checkbox"/> No <input type="checkbox"/> Yes	Incontinence or dribbling	<input type="checkbox"/> No <input type="checkbox"/> Yes		
		Kidney stones	<input type="checkbox"/> No <input type="checkbox"/> Yes	Endocrine	
Eyes		Sexual difficulty	<input type="checkbox"/> No <input type="checkbox"/> Yes	Glandular or hormone problem	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eye disease or injury	<input type="checkbox"/> No <input type="checkbox"/> Yes	Male – testicle pain	<input type="checkbox"/> No <input type="checkbox"/> Yes	Excessive thirst or urination	<input type="checkbox"/> No <input type="checkbox"/> Yes
Blurred or double vision	<input type="checkbox"/> No <input type="checkbox"/> Yes	Female – pain with periods	<input type="checkbox"/> No <input type="checkbox"/> Yes	Heat or cold intolerance	<input type="checkbox"/> No <input type="checkbox"/> Yes
		Female – irregular periods	<input type="checkbox"/> No <input type="checkbox"/> Yes	Skin becoming dryer	<input type="checkbox"/> No <input type="checkbox"/> Yes
Ears/Nose/Mouth/Throat		Female – vaginal discharge	<input type="checkbox"/> No <input type="checkbox"/> Yes	Change in hat or glove size	<input type="checkbox"/> No <input type="checkbox"/> Yes
Hearing loss or ringing	<input type="checkbox"/> No <input type="checkbox"/> Yes	Female – # of pregnancies	_____		
Earaches or drainage	<input type="checkbox"/> No <input type="checkbox"/> Yes	Female – # of miscarriages	_____	Hematologic/Lymphatic	
Chronic sinus problem or rhinitis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Female – date of last pap smear:	_____	Slow to heal after cuts	<input type="checkbox"/> No <input type="checkbox"/> Yes
Nose bleeds	<input type="checkbox"/> No <input type="checkbox"/> Yes			Bleeding or bruising tendency	<input type="checkbox"/> No <input type="checkbox"/> Yes
Mouth sores	<input type="checkbox"/> No <input type="checkbox"/> Yes	Musculoskeletal		Anemia	<input type="checkbox"/> No <input type="checkbox"/> Yes
Bleeding gums	<input type="checkbox"/> No <input type="checkbox"/> Yes	Joint pain	<input type="checkbox"/> No <input type="checkbox"/> Yes	Phlebitis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Bad breath or bad taste	<input type="checkbox"/> No <input type="checkbox"/> Yes	Joint stiffness or swelling	<input type="checkbox"/> No <input type="checkbox"/> Yes	Past transfusion	<input type="checkbox"/> No <input type="checkbox"/> Yes
Sore throat or voice change	<input type="checkbox"/> No <input type="checkbox"/> Yes	Weakness of muscles or joints	<input type="checkbox"/> No <input type="checkbox"/> Yes	Enlarged glands	<input type="checkbox"/> No <input type="checkbox"/> Yes
Swollen glands in neck	<input type="checkbox"/> No <input type="checkbox"/> Yes	Muscle pain or cramps	<input type="checkbox"/> No <input type="checkbox"/> Yes		
		Back pain	<input type="checkbox"/> No <input type="checkbox"/> Yes	Allergic/Immunologic	
Cardiovascular		Cold extremities	<input type="checkbox"/> No <input type="checkbox"/> Yes	History of skin reaction or other adverse reaction to:	
Heart trouble	<input type="checkbox"/> No <input type="checkbox"/> Yes	Difficulty in walking	<input type="checkbox"/> No <input type="checkbox"/> Yes	Penicillin or other antibiotics	<input type="checkbox"/> No <input type="checkbox"/> Yes
Chest pain or angina pectoris	<input type="checkbox"/> No <input type="checkbox"/> Yes			Morphine, Demerol or other narcotics	<input type="checkbox"/> No <input type="checkbox"/> Yes
Palpitation	<input type="checkbox"/> No <input type="checkbox"/> Yes	Integumentary (skin, breast)		Novocain or other anesthetics	<input type="checkbox"/> No <input type="checkbox"/> Yes
Shortness of breath	<input type="checkbox"/> No <input type="checkbox"/> Yes	Rash or itching	<input type="checkbox"/> No <input type="checkbox"/> Yes	Aspirin or other pain remedies	<input type="checkbox"/> No <input type="checkbox"/> Yes
Swelling of feet, ankles or hands	<input type="checkbox"/> No <input type="checkbox"/> Yes	Change in skin color	<input type="checkbox"/> No <input type="checkbox"/> Yes	Tetanus antitoxin or other serums	<input type="checkbox"/> No <input type="checkbox"/> Yes
		Change in hair or nails	<input type="checkbox"/> No <input type="checkbox"/> Yes	Iodine, Merthiolate or other antiseptic	<input type="checkbox"/> No <input type="checkbox"/> Yes
Respiratory		Varicose veins	<input type="checkbox"/> No <input type="checkbox"/> Yes	Other drugs/medications: _____	
Chronic or frequent coughs	<input type="checkbox"/> No <input type="checkbox"/> Yes	Breast pain	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	
Spitting up blood	<input type="checkbox"/> No <input type="checkbox"/> Yes	Breast lump	<input type="checkbox"/> No <input type="checkbox"/> Yes	Known food allergies: _____	
Shortness of breath	<input type="checkbox"/> No <input type="checkbox"/> Yes	Nipple discharge	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____	
Wheezing	<input type="checkbox"/> No <input type="checkbox"/> Yes			Environmental allergies: _____	
		Neurological		_____	
Gastrointestinal		Frequent or recurring headaches	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Loss of appetite	<input type="checkbox"/> No <input type="checkbox"/> Yes	Light headed or dizzy	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Change in bowel movements	<input type="checkbox"/> No <input type="checkbox"/> Yes	Convulsions or seizures	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Nausea or vomiting	<input type="checkbox"/> No <input type="checkbox"/> Yes	Numbness or tingling sensations	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Frequent diarrhea	<input type="checkbox"/> No <input type="checkbox"/> Yes	Tremors	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Painful bowel movements	<input type="checkbox"/> No <input type="checkbox"/> Yes	Paralysis	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Constipation	<input type="checkbox"/> No <input type="checkbox"/> Yes	Head injury	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Rectal bleeding or blood in stool	<input type="checkbox"/> No <input type="checkbox"/> Yes				
Abdominal pain	<input type="checkbox"/> No <input type="checkbox"/> Yes				

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient, Parent or Guardian

Date

Doctor's Review: _____

Signature of Physician

Date