# Auburn Family Health Center, P.C.

Gary R. Ensz, MD  Jeffrey G. Meade, MD  John A. Gill, MD,
Michael L. Zaruba, MD, FAAFP  Andrew C. Ensz, MD  Amanda L. Ensz, MD

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: _____
Address: _____
City, ST Zip _____
Date of Birth: _____
Gender: _____
Social Security #: _____
Email: _____
Marital Status: _____
Spouse's Name: (if applicable) _____
**PHARMACY:** _____

Home Phone: _____
Cell Phone: _____
Language: ☐ English ☐ Spanish ☐ Other ☐ Refuse
Race: ☐ White ☐ Black ☐ American Indian ☐ Hispanic ☐ Other ☐ Refuse
Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Refuse
Employer: _____
Work Phone: _____
Preferred Provider: (Please circle) Ensz Meade Gill Zaruba Andrew Amanda Lindsey

## MEMBERS IN HOUSEHOLD ON PATIENT ACCOUNT

| Name: | Birthdate: | Name: | Birthdate: |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

## EMERGENCY CONTACT

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

## HEAD OF HOUSEHOLD / RESPONSIBLE PARTY

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

## INSURANCE

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

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

Patient Name: _____ Birthdate: _____

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

| Previous Hospitalizations/Surgeries/Serious Illnesses | When? | Hospital, City, State |
|---|---|---|
| ☐ 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

- Good general health lately ☐ No ☐ Yes
- Recent weight change ☐ No ☐ Yes
- Fever ☐ No ☐ Yes
- Fatigue ☐ No ☐ Yes
- Headaches ☐ No ☐ Yes

### Eyes

- Eye disease or injury ☐ No ☐ Yes
- Blurred or double vision ☐ No ☐ Yes

### Ears/Nose/Mouth/Throat

- Hearing loss or ringing ☐ No ☐ Yes
- Earaches or drainage ☐ No ☐ Yes
- Chronic sinus problem or rhinitis ☐ No ☐ Yes
- Nose bleeds ☐ No ☐ Yes
- Mouth sores ☐ No ☐ Yes
- Bleeding gums ☐ No ☐ Yes
- Bad breath or bad taste ☐ No ☐ Yes
- Sore throat or voice change ☐ No ☐ Yes
- Swollen glands in neck ☐ No ☐ Yes

### Cardiovascular

- Heart trouble ☐ No ☐ Yes
- Chest pain or angina pectoris ☐ No ☐ Yes
- Palpitation ☐ No ☐ Yes
- Shortness of breath ☐ No ☐ Yes
- Swelling of feet, ankles or hands ☐ No ☐ Yes

### Respiratory

- Chronic or frequent coughs ☐ No ☐ Yes
- Spitting up blood ☐ No ☐ Yes
- Shortness of breath ☐ No ☐ Yes
- Wheezing ☐ No ☐ Yes

### Gastrointestinal

- Loss of appetite ☐ No ☐ Yes
- Change in bowel movements ☐ No ☐ Yes
- Nausea or vomiting ☐ No ☐ Yes
- Frequent diarrhea ☐ No ☐ Yes
- Painful bowel movements ☐ No ☐ Yes
- Constipation ☐ No ☐ Yes
- Rectal bleeding or blood in stool ☐ No ☐ Yes
- Abdominal pain ☐ No ☐ Yes

### Genitourinary

- Frequent urination ☐ No ☐ Yes
- Burning or painful urination ☐ No ☐ Yes
- Blood in urine ☐ No ☐ Yes
- Straining while urinating ☐ No ☐ Yes
- Incontinence or dribbling ☐ No ☐ Yes
- Kidney stones ☐ No ☐ Yes
- Sexual difficulty ☐ No ☐ Yes
- Male – testicle pain ☐ No ☐ Yes
- Female – pain with periods ☐ No ☐ Yes
- Female – irregular periods ☐ No ☐ Yes
- Female – vaginal discharge ☐ No ☐ Yes
- Female – # of pregnancies _____
- Female – # of miscarriages _____
- Female – date of last pap smear: _____

### Musculoskeletal

- Joint pain ☐ No ☐ Yes
- Joint stiffness or swelling ☐ No ☐ Yes
- Weakness of muscles or joints ☐ No ☐ Yes
- Muscle pain or cramps ☐ No ☐ Yes
- Back pain ☐ No ☐ Yes
- Cold extremities ☐ No ☐ Yes
- Difficulty in walking ☐ No ☐ Yes

### Integumentary (skin, breast)

- Rash or itching ☐ No ☐ Yes
- Change in skin color ☐ No ☐ Yes
- Change in hair or nails ☐ No ☐ Yes
- Varicose veins ☐ No ☐ Yes
- Breast pain ☐ No ☐ Yes
- Breast lump ☐ No ☐ Yes
- Nipple discharge ☐ No ☐ Yes

### Neurological

- Frequent or recurring headaches ☐ No ☐ Yes
- Light headed or dizzy ☐ No ☐ Yes
- Convulsions or seizures ☐ No ☐ Yes
- Numbness or tingling sensations ☐ No ☐ Yes
- Tremors ☐ No ☐ Yes
- Paralysis ☐ No ☐ Yes
- Head injury ☐ No ☐ Yes

### Psychiatric

- Memory loss or confusion ☐ No ☐ Yes
- Nervousness ☐ No ☐ Yes
- Depression ☐ No ☐ Yes
- Insomnia ☐ No ☐ Yes

### Endocrine

- Glandular or hormone problem ☐ No ☐ Yes
- Excessive thirst or urination ☐ No ☐ Yes
- Heat or cold intolerance ☐ No ☐ Yes
- Skin becoming dryer ☐ No ☐ Yes
- Change in hat or glove size ☐ No ☐ Yes

### Hematologic/Lymphatic

- Slow to heal after cuts ☐ No ☐ Yes
- Bleeding or bruising tendency ☐ No ☐ Yes
- Anemia ☐ No ☐ Yes
- Phlebitis ☐ No ☐ Yes
- Past transfusion ☐ No ☐ Yes
- Enlarged glands ☐ No ☐ Yes

### Allergic/Immunologic

History of skin reaction or other adverse reaction to:

- Penicillin or other antibiotics ☐ No ☐ Yes
- Morphine, Demerol or other narcotics ☐ No ☐ Yes
- Novocain or other anesthetics ☐ No ☐ Yes
- Aspirin or other pain remedies ☐ No ☐ Yes
- Tetanus antitoxin or other serums ☐ No ☐ Yes
- Iodine, Merthiolate or other antiseptic ☐ No ☐ Yes

Other drugs/medications: _____

_____

Known food allergies: _____

_____

Environmental allergies: _____

_____

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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