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: _____ Home Phone: _____
Address: _____ Cell Phone: _____
City, ST Zip _____
Language: ☐ English ☐ Spanish ☐ Other ☐ Refuse
Date of Birth: _____ Race: ☐ White ☐ Black ☐ American Indian
Gender: _____ ☐ Hispanic ☐ Other ☐ Refuse
Social Security #: _____ Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Refuse
Email: _____
Marital Status: _____ Employer: _____
Spouse's Name: (if applicable) _____ Work Phone: _____
PHARMACY: _____ Preferred Provider: (Please circle) Ensz Meade Gill Zaruba Andrew Amanda Lindsey

MEMBERS IN HOUSEHOLD ON PATIENT ACCOUNT

Name:	Birthdate:	Name:	Birthdate:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 _____
Employer: _____
Date of Birth: _____ 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: _____

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: _____

_____

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