INTERNAL MEDICINE PHYSICIANS P.C.

PATIENT REGISTRATION **TODAY'S DATE** _____

FIRST NAME _____ MIDDLE INITIAL_____ LAST NAME_____

PREFERRED NAME (if different than legal name) _____ DATE OF BIRTH _____ GENDER_____

SOCIAL SECURITY # _____ MARITAL STATUS Single Married Divorced Widowed Other_____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____WORK_____ CELL PHONE _____

PATIENT EMAIL_____

EMPLOYER _____ OCCUPATION _____

EMERGENCY CONTACT_____ PHONE _____ HOW RELATED?_____

IF MARRIED, SPOUSES'S NAME _____ SOCIAL SECURITY # _____

SPOUSE'S EMPLOYER _____ DATE OF BIRTH _____

GUARANTOR (PERSON RESPONSIBLE FOR BILL.) IF SAME AS PATIENT, CHECK SAME HERE ☐

NAME _____ RELATION TO PATIENT _____

ADDRESS _____ DATE OF BIRTH _____

CITY _____ STATE _____ ZIP _____ SOCIAL SECURITY # _____

EMPLOYER _____ PHONE _____ HOME PHONE # _____

INSURANCE COVERAGE INFORMATION
PLEASE BE PREPARED TO PRESENT YOUR INSURANCE CARD(S) AT EVERY VISIT

Primary Insurance

_____

ADDRESS _____

MEMBER ID# _____GROUP #_____

SUBSCRIBER _____

DATE OF BIRTH _____

RELATION TO PATIENT _____

Secondary Insurance

_____

ADDRESS _____

MEMBER ID #_____ GROUP # _____

SUBSCRIBER _____

DATE OF BIRTH _____

RELATION TO PATIENT _____

INSURANCE AND ASSIGNMENT OF BENEFITS AUTHORIZATION INFORMATION

I hereby authorize treatment of the above-named patient and agree to pay all charges for treatment regardless of insurance coverage or the pendency of insurance claims.

I authorize the release of all medical information to the above insurance carriers that is pertinent to my medical care and necessary to process my insurance claims. I will assign all medical and surgical benefits to Internal Medicine Physicians, P.C. A photocopy of this form shall be as valid as the original. I understand that I can withdraw this medical benefit assignment at any time by notifying this office in writing.

I HAVE READ THIS INFORMATION THOROUGHLY AND UNDERSTAND IT.

PATIENT SIGNATURE _____DATE _____

(PARENT OR LEGAL GUARDIAN IF MINOR)

Office Use Only: date & initials_____

INTERNAL MEDICINE PHYSICIANS P.C.

PRINT Patient Name:

_____

Patient Date of Birth:

_____ / _____/ _____

FINANCIAL & NO SHOW POLICY

Payment in full is required at the time services are rendered. If you are unable to remit payment in full, you may be required to speak with a patient accounts representative to make alternate payment arrangements.

As a courtesy, we will file claims with your primary and secondary insurance (if applicable) providing we have your *Assignment of Benefits* (see below) and **current and accurate** insurance information from you. Payment for services is ultimately the patient's responsibility. **NOT ALL SERVICES ARE A COVERED BENEFIT OF ALL PLANS.** Your insurance coverage is an agreement between you and your insurance company. Some insurance plans have timely filing limits. If the timely filing limit has been exceeded and you failed to provide accurate insurance information, you will be responsible for ALL incurred charges. **ALL** copays are due at the time of service. Presentation of your insurance card will be expected at **each** appointment.

All patients receiving state funded healthcare benefits (ie: Medicaid) are required to provide accurate identification information for the SPECIFIC PLAN for which they are enrolled. **NOT ALL SERVICES ARE A COVERED BENEFIT.** Review your Medicaid manual if you have questions regarding your specific coverage. Presentation of your state issued Medicaid card will be expected at **each** appointment.

As a courtesy, will file claims with your workers compensation carrier or other third party liability carrier(s). All billing information must be provided by the patient in advance and must be **accurate**. Ultimately, all charges are the responsibility of the patient.

If you have questions concerning insurance payment or denial of your claim, you should **first contact your insurance provider** to obtain further information. **ALL BALANCES ARE DUE IN FULL** upon receipt of a mailed statement. If you are unable to remit payment in full, you are required to contact our billing office at 888-342-3689 to speak with a patient accounts representative. Failure to remit payment or correspond with the billing office may result in your account being subject to further collection efforts. Accounts subject to additional collection efforts may result in the responsible billing party and associated family members having medical services suspended and subject to termination from the practice.

Returned checks may be subject to a $30.00 fee per occurrence.

Unless other arrangements have been made and agreed to by the parties in writing, the amount due as reflected on a statement is due when services are rendered. A late payment charge of one and one-third percent (1 1/3%) per month may be charged on any unpaid amounts from and after the 31st day following the date of the statement; provided, however, in the event the patient has health insurance and a claim is submitted, the late payment charges will apply from and after the 61st days following the date the insurance provider has determined what the patient's financial responsibility (e.g., deductible/co-insurance) is for the medical services rendered. In the event the patient's account is sent to a collection agency, the patient (or patient's responsible party, as applicable) agrees to reimburse IMP for the fees charged IMP by such collection agency, which fees may be based upon a percentage not to exceed 33 1/3% of the patient's outstanding account balance, and all other costs and expenses, including reasonable attorneys' fees, IMP incurs in its collection efforts.

No-Show/Late Arrival Policy:
A minimum 2 hour notice is required to cancel appointments. If the required notice is not received, you may be charged a $25.00 fee. This fee is NOT covered by your insurance. If you are more than 10 minutes late for your appointment, you may be required to reschedule.

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS
I have read and agree to the terms and conditions set forth above. I understand that I am responsible for and agree to pay all charges regardless of insurance coverage or pendency of claims. I authorize the release of all medical information necessary to process my health insurance claim and request payment of benefits be made to Internal Medicine Physicians, P.C.. A photocopy of this agreement shall be as valid as the original. I understand that I can withdraw this medical benefit assignment at any time by notifying this office in writing.

Patient or Responsible Party Signature _____ Date _____

INTERNAL MEDICINE PHYSICIANS P.C.
& FAMILY PHYSICIANS

Appointment reminders can now be made by phone call, text or e-mail. Please mark your preference below and list what number or e-mail address would be best to receive this reminder. Unfortunately our system only allows for **ONE** option, so please pick the **ONE** you most prefer.

☐ Phone call _____

Phone #

☐ Text _____

Phone #

☐ E-mail _____

e-mail address

Name (print) _____

Sign _____

Date _____

INTERNAL MEDICINE AND FAMILY PHYSICIANS, P.C.

CONTACT AUTHORIZATION

Patient Name:	Date of Birth:

Internal Medicine and Family Physicians, P.C. is committed to protecting our patient's privacy. Without your authorization, messages left on voicemail or with other individuals will be limited. The only information left will be limited to our office name and phone numbers. If you prefer more complete information be provided, please fill out the form below.

Please contact me as follows:

Best daytime contact #: ( ) _____

- ☐ Leave message-only provider name and phone #
- ☐ Leave message-lab/test results, med changes, etc.

Any written communication will go to the address on file.
Please verify we have your current address.

I hereby give permission to release my medical information to the following individuals (examples: spouse, children, sibling, friend, etc.):

- _____
- _____
- _____
- _____
- _____

Internal Medicine and Family Physicians, P.C. Staff: changes in contact information may require system changes and documentation on a Privacy Practices Action Form (PPAF).

Please sign below to authorize the above contact information. Changes to this form will require a new form to be completed.

Sign:	Date:

Screening Assessment

Patient Name:_____ Today's Date:_____/_____/_____

Date of Birth:_____/_____/_____ Patient Phone: (___) - _____- _____

Symptoms	Severity				Frequency		
	N/A	Mild	Moderate	Severe	Occasionally/Never	Seasonal	Most of the Year/Daily
Itchy Eyes	0	1	2	3	0	1	2
Watery Eyes	0	1	2	3	0	1	2
Red Eyes	0	1	2	3	0	1	2
Runny Nose	0	1	2	3	0	1	2
Itchy Nose	0	1	2	3	0	1	2
Stuffy Nose	0	1	2	3	0	1	2
Frequent Sneezing	0	1	2	3	0	1	2

Circle One

1. Have you ever been diagnosed with asthma, recurrent wheezing, or recurrent bronchitis?	Yes	No
2. Have you ever been diagnosed with atopic dermatitis, eczema, or recurrent sinusitis?	Yes	No
3. Do you take prescription or OTC medications to manage your allergy symptoms?	Yes	No

Circle each medication that you use to manage your allergy symptoms:

Allegra (Fexofenadine) Xyzal (Levocetirizine) Benadryl (Diphenhydramine) Zyrtec (Cetirizine)

Claritin (Loratadine) Singulair (Montelukast) Clarinex (Desloratadine) Other: _____

4. Do you take any steroidal or non-steroidal anti-inflammatory drugs?	Yes	No

Circle each medication that you use to treat inflammation:

Aleve (Naproxen) Aspirin Advil/Motrin (Ibuprofen) Prednisone Other: _____

5. Have you ever had a reaction to any foods in the past? If so, describe the event.	Yes	No

Circle the reaction(s) you experienced during the event(s):

Tingling/itchy mouth Hives/rash/eczema Swelling Wheezing/difficulty breathing

Abdominal pain/ diarrhea/nausea/vomiting Dizziness/lightheadedness/fainting

If the answer to question 5 was "No", please skip questions 6 and 7.

6. Do you have any family members that have been diagnosed or have suspected allergies? If so, list those family members and their diagnosed/suspected allergies.	Yes	No
7. Have you ever been tested for food allergies?	Yes	No

Patient/Guardian Signature: _____ **Date:** _____

Office Use Only:						
Sum of severity of symptoms (0-21)		**Sum of frequency of symptoms (0-14)**			**Order 95004?**	
					Yes	No
Diagnosis (circle one)	**J30.89**	**J30.1**	**J30.2**	**Other** _____	**Circle Test(s)**	
					Environmental	Food
Provider Signature:			**Date:**		Environmental & Food	

210812

17030 Lakeside Hills Plaza, Suite 102 ● Omaha, NE 68130 ● Phone (402) 758-5800
Fax (402) 758-5809

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:	
Date of Birth:	
Social Security Number:	
Patient Address:	
Telephone Number:	
Purpose for Record Request:	☐ **Continuation of Care** ☐ **Transfer of Care** ☐ **Other** _____

I hereby request and authorize:

Name:

Address:

Phone #:

Fax #:

to release all my medical record to:

Name: INTERNAL MEDICINE & FAMILY PHYSICIANS

Address: 17030 Lakeside Hills Plaza, Suite 102 Omaha, NE 68130

Phone #: 402-758-5800

Fax #: 402-758-5809

I understand the information may include information regarding drug or alcohol abuse, mental health and/or HIV related information. I release the above from all legal responsibility or liability that may arise from the act I have authorized.

I understand that this authorization is valid for one year after the date of my signature. I also understand that this authorization can be revoked, except to the extent that action has already been taken to comply with.

_____ _____

Date Signature of Patient or Legal Representative

_____

Legal Representative's Relationship to Patient

17030 Lakeside Hills Plaza, Ste 102
Omaha, NE 68130
Phone (402) 758-5800
Fax (402) 758-5809

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY NOTICE

The undersigned hereby acknowledges receipt of the Internal Medicine Physicians, P.C. Summary Notice of Privacy Practices and attached Notice of Privacy Practices.

_____ _____

Signature Date

_____

Print Name of Patient

(If an authorized representative)

_____

Print name of Representative

_____

Relationship to Patient

INTERNAL MEDICINE PHYSICIANS P.C.
& FAMILY PHYSICIANS

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully and retain a copy for your records.

Under applicable law, Internal Medicine and Family Physicians, P.C. (referred to as "we," "our" or "IMP") is required to protect the privacy of your individual health information (information we refer to in this notice as "Protected Health Information" or "PHI"). We are also required to provide you with this notice regarding our policies and procedures regarding your PHI, and to abide by the terms of this notice, as it may be updated from time to time.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We are permitted to make certain types of uses and disclosures under applicable law for treatment, payment and healthcare operations purposes without obtaining your authorization.

For treatment purposes, we may use and disclose your PHI for the purpose of providing, coordinating or managing the delivery of healthcare services to you by one or more healthcare providers, including doctors, nurses, technicians, medical students or other hospital personnel who are involved in taking care of you. For example, another physician may consult with us regarding your condition or treatment.

For payment purposes, we may use and disclose your PHI to obtain payment or reimbursement for providing healthcare services, such as when we request payment for your insurer, health plan or a government benefit program. For healthcare operations purposes, we may use and disclose your PHI in a number of ways, including for quality assessment and improvement for planning and development, management and administration. Your information could be used, for example, to assist in the evaluation of the quality of care you were provided. Healthcare operations also include conducting training programs in which students, trainees or practitioners in areas of healthcare learn under supervision to practice or improve their skills.

- In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

- Where applicable, we may disclose your health information to your health plan sponsor. This applies to a group health plan, a health insurance issuer or a Health Maintenance Organization (HMO) with respect to a group health plan.

We may use and disclose your PHI without your authorization for treatment, payment and healthcare operations purposes either within IMP or with other healthcare providers, health plans and those that process healthcare claims benefits and related information. We are also permitted to share your PHI without your authorization in the following instances.

We may also use or disclose your PHI as permitted or required by law including, for example:

- To public health authorities for the purpose of preventing or controlling disease or other public health purposes.

- To appropriate government authorities to report about victims of suspected abuse, neglect or domestic violence.

- To the Food and Drug Administration to report quality, safety, or effectiveness of the FDA regulated products or activities.

- In certain limited circumstances to an employer such as if we are asked to evaluate or treat a work-related illness or injury for workers' compensation purposes.

- To qualified health authorities for purposes of conducting health oversight activities.

- In response to subpoenas, discovery requests or other lawful legal processes in the course of a judicial or administrative proceeding.

- To law enforcement authorities as required or permitted by law such as, for example, to report a death, a crime on our premises or if it appears necessary to alert law enforcement to respond to an emergency.

- To persons involved with respect to matters pertaining to a decedent or relating to cadaveric organ, eye or tissue donation.

- In certain instances, for research purposes.

- We may disclose your PHI if we believe, in good faith, it is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

- We may disclose your PHI for certain specialized government functions such as, for example, to Armed Forces Authorities with reference to military personnel or for national security purposes.

Unless you object, we may also disclose to a member of your family or other relative, to a close personal friend or to any other person identified by your PHI that is directly relevant to that person's involvement with your care or payment related to your care. In addition, unless you object, orally or in writing, to a doctor, nurse or our privacy policy officer, we may use or disclose the PHI to notify, identify or locate a member of your family, your personal representative, another person responsible for your care or certain disaster relief agencies of your location, general condition or death. If you are incapacitated, there is an emergency or you otherwise do not have the opportunity to object to this use of disclosure, we will do what in our judgment is in your best interest regarding such disclosures and will disclose only the information that is directly relevant to the person's involvement with your healthcare. We will also use our judgment and experience regarding your best interest in allowing people to pick up filled prescriptions, medical supplies, x-rays or other similar forms of PHI. Other uses and disclosures will be made only with your written authorization, and you may revoke your authorization by notifying the Privacy Officer.

YOUR PRIVACY RIGHTS

To Request Restrictions. You have the right to request restrictions on our use and disclosure of your PHI. We are not required to agree to your request. If we do agree to a restriction, we will abide by that restriction except in an emergency.

To Limit Communications. You have the right to receive confidential communications about your own PHI by alternative means or at alternative locations. This means that you may, for example, designate we contact you only via e-mail or at work rather than at home. To request communications via alternative means or alternative locations, you must submit a written request to the Privacy Officer. All reasonable requests will be granted.

To Access and Copy Health Information. You have the right to inspect and copy any PHI about you other than psychotherapy notes, information compiled in anticipation of or for use in civil, criminal or administrative proceedings or certain information governed by the Clinical Laboratory Improvement Act. To arrange for access to your records, or to receive a copy of your records, you should submit a written request to the Privacy Officer. If you request copies, you may be charged a reasonable fee based on our costs for labor, copying and mailing the requested information. Despite your general right to access your PHI, access may be denied in some limited circumstances as provided by law. In certain situations, if access is denied you have the right to have the decision reviewed by a healthcare professional who did not participate in the original decision. If access is ultimately denied, the reasons for that denial will be provided to you in writing.

To Request Amendment. You may request your PHI be amended. Your request may be denied if the information in question: was not created by us (unless you show the original source of the information is no longer available to seek amendment from), is not part of our records, is not the type of information that would be available to you for inspection or copying (for example, psychotherapy notes), or is accurate and complete. If your request to amend your PHI is denied, you may submit a written statement disagreeing with the denial, which we will keep on file and distribute with all future disclosures of the information to which it relates. Requests to amend PHI must be submitted in writing to the Privacy Officer.

To an Accounting of Disclosure. You have to right to an accounting of any disclosures of you PHI made during the six-year period preceding the date of your request beginning from April 14, 2003. However, the following disclosures will not be accounted for: (i) disclosures made for the purpose of carrying out treatment, payment or healthcare operations, (ii) disclosures made to you, (iii) disclosures of information maintained in our patient directory, disclosures made to persons involved in your care, or for the purpose of notifying your family or friends your whereabouts, (iv) disclosures for national security or intelligence purposes, (v) disclosures to correctional institutions or law enforcement officials who had you in custody at the time of disclosure, (vi) disclosure that occurred prior to April 14, 2003, (vii) disclosures that are part of a limited data set, (ix) disclosures that are incidental to another permissible use or disclosure, or (x) disclosures made to a health oversight agency or law enforcement official, but only if the agency or official asks us not to account to you for such disclosures and only for the limited period of time covered by that request. The accounting will include the date of each disclosure, the name of the entity or person who received the information and that person's address (if known) and a brief description of the information disclosed and the purpose of the disclosure. To request an accounting of disclosures, submit a written request to the Privacy Officer.

Our Duties

1)We are required by law to maintain the privacy of your PHI connected with this Notice and to provide you with this Notice of our legal duties and privacy practices.

2)We are required to abide by the terms of this Notice. We reserve the right to change the terms of this Notice and to make those changes applicable to all health information we maintain. Any changes to this Notice will be posted in our office, if applicable, and at our facilities, and will be available from us upon request.

Complaints

You can complain to us and to the federal Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated. To lodge a complaint with us, please file a written complaint with the Privacy Officer. This person will also provide you with further information about our privacy policies upon request. No action will be taken against you for filing a complaint.

For further information concerning our privacy policy, your privacy rights, or the complaint procedure, please contact our Privacy Officer: Dr. David Sharp, telephone number (402) 758-5800, fax number (402) 758-5809 or by mail 17030 Lakeside Hills Plaza, Suite 102, Omaha, NE 68130

INTERNAL MEDICINE PHYSICIANS P.C.
& FAMILY PHYSICIANS

17030 Lakeside Hills Plaza, Ste 102/104

Omaha, NE 68130

&

16909 Lakeside Hills Court, Ste 105

Omaha, NE 68130

Phone: (402) 758-5800

Fax: (402) 758-5809

www.impomaha.com

INTERNAL MEDICINE PHYSICIANS P.C.
& FAMILY PHYSICIANS

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**		
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed				
Previous or referring doctor:		**Date last seen by previous Dr:**			
Pharmacy:		**Date of last physical exam:**			

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Other:			
Immunizations and date last received:	☐ Tetanus		☐ Pneumonia	
	☐ Hepatitis		☐ Chickenpox	
	☐ Influenza		☐ MMR (*Measles, Mumps, Rubella)*	
	☐ Shingles		☐ Other:	

List any medical problems that other doctors have diagnosed	

List any specialists you have seen (past or present)

Surgeries/Procedures		
Year	Reason	Location
	Cardiac Stress Test	
	EKG	
	Colonoscopy	
	PSA	
	Pap Smear	
	Mammogram	

List your prescribed medications as well as over-the-counter medications (such as vitamins and inhalers) ***USE BACK IF NEEDED***		
Name of Medication	Dose	Frequency Taken
Allergies to Medications ***PLEASE LIST NON-MEDICATION ALLERGIES ON BACK OF PAGE*		
Type	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary (No exercise)						
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)						
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)						
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)						
Diet	Are you "dieting"?					☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?					☐ Yes	☐ No
	How would you describe your diet?						
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	# of cups/cans per day?		
Alcohol	Do you drink alcohol?					☐ Yes	☐ No
	If yes, what kind?						
	How many drinks per week?						
	Are you concerned about the amount you drink?					☐ Yes	☐ No
	Have you considered stopping?					☐ Yes	☐ No
Tobacco	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day			
	☐ # of years	☐ Or year quit					
Drugs	Do you currently use "recreational" or "street drugs"? Type:					☐ Yes	☐ No
	Have you used "recreational" or "street drugs" in the past? Type:					☐ Yes	☐ No
Personal Safety	Do you live alone?					☐ Yes	☐ No
	Do you have frequent falls?					☐ Yes	☐ No
	Do you have vision or hearing loss?					☐ Yes	☐ No
	Physical and/or mental abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?					☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?				☐ Yes ☐ No
Do you feel depressed?				☐ Yes ☐ No
Do you panic when stressed?				☐ Yes ☐ No
Have you ever attempted suicide?				☐ Yes ☐ No
Have you ever seriously thought about hurting yourself?				☐ Yes ☐ No
Do you have trouble sleeping?				☐ Yes ☐ No
If yes,	☐ Insomnia	☐ Snoring	☐ Sleep Apnea	☐ Other:

ADVANCED DIRECTIVE

Do you have an advanced directive or living will?	☐ Yes ☐ No

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Sign: _____

Date: _____