Welcome to Lincoln Medical Education Partnership

We are excited to meet you and would like to personally thank you for choosing Lincoln Medical Education Partnership (LMEP) to be part of your medical home! We hope you find the following information helpful in preparing you for your first appointment.

We provide integrated medical and behavioral health services including preventative and wellness visits, acute and chronic illness management, as well as acupuncture and counseling services. As your medical home, we will care for you in the office, hospital, nursing home or home visits when appropriate. We provide x-ray, laboratory and a variety of in-office surgical procedures as well as complete maternity care, delivery of your baby and well-child visits afterward. We are also happy to organize any referrals and specialist care efficiently.

Lincoln Medical Education Partnership hours and appointments
Our clinic/behavioral health appointment hours are 8am – 5pm Monday – Friday by appointment. If you have a message for your medical team after hours, you can communicate by sending us messages through our online portal any time of day or night.

You Have the Right to:
- Receive services regardless of age, gender, race/ethnicity, disability, religion/spiritual beliefs, or sexual preference.
- Take part in your medical and/or behavioral health care and treatment decisions.
- Be told in advance about care and treatment, and of any changes in care and treatment that may affect your well-being.
- Privacy of all records, information shared, and personal information.
- Decide to stop receiving services without being punished.
- Be told of the reasons for not allowing you to receive any services.
- Be free from abuse and neglect.
- Be treated with respect and dignity.
- Request that your care be given by a different clinic/organization.
- Make a complaint, make recommendations, and tell someone about your concerns without unfairness or retaliation and to have those complaints and concerns addressed. Complaints and concerns may be filed with the LMEP Compliance Officer at (402) 327-6851, the LMEP President at (402) 327-6801 or with Nebraska Health and Human Services Regulation and Licensure at (402) 471-0316.
- Be free from transfer or discharge for no good reason.
- Be told prior to admission of any fees for care, treatment, or related charges.

What about emergencies?
We provide 24/7 on-call medical services. If you need non-life-threatening medical services after hours, please call our on-call physician at 402-483-4571.
If you are struggling with mental health concerns and need someone to talk to after hours, please call the CenterPointe Crisis Response Line at (402) 475-6695.
If you have a life-threatening medical or behavioral health emergency or severe injury, please call 911 or go to the nearest hospital/emergency department.

Patient Information:

Name _____ Birthdate _____
LAST *FIRST* *MIDDLE INITIAL*

Street Address _____Apt/Unit Number_____

City _____State _____ ZIP _____

Home Phone _____ Cell Phone _____Work Phone _____
Ok to text? Y or N

Email _____ Social Security # _____
FOR PORTAL COMMUNICATION

Patient's Employer _____ Occupation_____

Gender: ☐Male ☐Female ☐Transgender Male ☐Transgender Female ☐Other_____

Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Other _____

Preferred Language:☐English☐Spanish☐Arabic☐Vietnamese☐Other_____Ethnicity:☐Hispanic☐Non-Hispanic

Race:☐Caucasian ☐African-American ☐Native American ☐Asian Pacific Islander ☐Multi-Racial ☐Other_____

If a minor, please list:

Parent/Guardian Name(s) _____ Phone_____

Relationship to patient_____

Parent/Guardian Name(s) _____Phone _____

Relationship to patient_____

Guarantor Information (Correspondence)

How are you related to the patient? ☐Self ☐Spouse ☐Parent ☐Child ☐Other_____

Street Address _____Apt/Unit Number_____

City _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____ Work Phone _____

Birthdate _____ Social Security # _____

Gender: ☐Male ☐Female ☐Transgender Male ☐Transgender Female ☐Other_____

Employer's Name _____

Emergency Contact (not in household)

Name:_____Phone:_____Relationship:_____

Insurance Information

☐I do not have insurance

☐I have insurance (front desk will need to scan your card)

Primary Insurance Company_____ Birthdate _____

Policyholder's Name _____ Relationship to Patient:☐Self☐Spouse☐Child☐Other

Gender: ☐Male ☐Female ☐Transgender Male ☐Transgender Female ☐Other_____

Insurance ID_____ Group ID_____

Secondary/Supplemental Insurance Company _____

Policyholder's Name _____ Relationship to Patient:☐Self☐Spouse☐Child☐Other

Gender: ☐Male ☐Female ☐Transgender Male ☐Transgender Female ☐Other_____

Insurance ID_____ Group ID_____

Please list the names & types of specialists you see (if any):

_____ _____

_____ _____

_____ _____

Preferred Pharmacy (name & location) **Preferred Hospital**

_____ _____

How did you hear about us?

☐Google ☐Social Media ☐Family/Friend ☐Physician referral ☐Other_____

- Please note that unless otherwise requested in writing, mail and telephone messages will be received at the home address and phone number listed under demographic information

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Adult Health Questionnaire

Over the past two weeks, how often have you been bothered by the following problems?				
	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				

Family History			
Family Member	Medical Condition	Age	Cause of death
Father			
Mother			
Siblings			
Children			
Extended Family			

Social History			
Home History	Who do you live with? Do you feel safe at home? ☐Yes☐ No	**Education/Work History**	What level of school did you complete? Current occupation?
Sexual History	Sexual orientation? ☐heterosexual ☐bisexual ☐celibate ☐homosexual Multiple sexual partners? ☐Yes☐No	**Tobacco History**	☐Never used ☐Current use, since_____ ☐Past use, quit year_____ Please specify type (check all that apply) ☐cigarettes ☐chew ☐pipe ☐snuff ☐cigar ☐e-cigarette
Alcohol Use History	☐No/Never used ☐Yes, current use. # times per week:_____ #drinks each time:_____ Specify type:_____ (beer, liquor, wine)	**Recreational Drug Use History**	☐Never used ☐Current use, since_____ ☐Past use, quit year_____ Please specify type (check all that apply) ☐marijuana ☐cocaine ☐methamphetamine ☐opiates ☐other_____
Exercise History	Do you exercise regularly? ☐Yes ☐No	**Caffeine use history**	Do you use caffeine daily? ☐Yes ☐No
Advanced care planning	Do you have a living will? ☐No ☐Yes, specify type:_____ Do you have a medical power of attorney? ☐No ☐Yes, who:		

Allergies (please list reaction)	

Do you have any additional medical conditions you think we should know about?	
Have you ever had a surgery, hospitalization or blood transfusion? Please list and include approximate date	

Please list all of your medications – prescription and over-the-counter
(Bring in all of your meds to your first visit)

Medication	Dose	Why do you take this medication?

Please select all that apply	Yes	No	
Have you ever been diagnosed with depression or anxiety?			
Have you ever been diagnosed with a cancer?			Type?
			Date, Location
Have you ever had a colonoscopy?			
Have you ever had a mammogram?			
Have you ever had a Pap smear?			
Have you ever had a bone density test?			
Appendix removed?			
Tonsils removed?			
Gallbladder removed?			
Tubal ligation or vasectomy?			

Immunization History	Yes	No
Did you receive childhood immunizations?		
Do you have your shot records?		
Tetanus booster shot?		
Pneumonia shot?		
Flu shot?		
Hepatitis B vaccine series?		

Women's Health questions

Age of first period:_____ Last period date:_____
Regular periods: ☐Yes ☐No
Birth control method:_____

# of pregnancies:_____ # of living children:_____
# of miscarriages:_____ # of abortions:_____
# of vaginal deliveries:_____
# of C-section deliveries:_____

Chronic Medical Conditions				**Psychiatric**		
Please select all that apply	Yes	No	Date		Yes	No
Asthma / COPD				Depression		
High blood pressure				Anxiety		
Diabetes				Sleep problems		
Thyroid problems				Alcohol abuse		
Heart disease				Drug abuse		
Other (list below)						

Review of Systems

General	Yes		No
Fevers			
Night sweats			
Weight gain		How much?	
Weight loss		How much?	
Exercise intolerance			

Eyes	Yes		No
Dry/irritated/painful eyes			
Vision changes			
Ever seen by eye doctor?		When?	

Ears/Nose/Mouth/Throat	Yes		No
Difficulty hearing			
Ear pain			
Frequent nosebleeds			
Nose/sinus problems			
Bleeding gums			
Snoring			
Dry mouth			
Mouth/teeth problems			

Cardiovascular	Yes		No
Chest pain			
Arm pain on exertion			
Shortness of breath – walking			
Shortness of breath – lying			
Palpitations			
Heart murmur			
Lightheaded on standing			

Respiratory	Yes		No
Cough			
Wheezing			
Shortness of breath			
Coughing up blood			
Sleep apnea			
Use a CPAP machine			

Gastrointestinal	Yes		No
Abdominal pain			
Nausea or vomiting			
Diarrhea			
Constipation			
Reflux			
Blood or black in stool			
Trouble swallowing			

Genitourinary	Yes		No
Loss of urine			
Difficulty urinating			
Blood in urine			
Increased frequency			
Incomplete emptying			

Musculoskeletal	Yes		No
Muscle pain			
Muscle weakness			
Joint pain			
Back pain			
Swelling in extremities			

Skin	Yes		No
Abnormal mole			
Jaundice			
Rash			
Laceration			
Growth/lesions			
Ever seen dermatologist?		Who?	

Neurologic	Yes		No
Loss of consciousness			
Weakness			
Numbness			
Seizures			
Dizziness			
Headaches/migraines			
Restless legs			

Psychiatric	Yes		No
Depression			
Anxiety			
Sleep disturbance			
Safe in relationship			
Alcohol/drug abuse			

Endocrine	Yes		No
Fatigue			
Hair loss			
Cold intolerance			

Allergic	Yes		No
Runny nose			
Itching			
Hives			

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Medical Record Release Authorization

Patient Name _____Date of Birth_____

SSN# _____Home Phone _____Cell Phone_____

Address _____City/State/Zip _____

Email Address _____

A) I hereby authorize records FROM:

Name _____

Address _____

City/State/Zip _____

Phone# _____Fax# _____

B) To be released TO:

Name _____

Address _____

City/State/Zip _____

Phone# _____Fax# _____

C) For the purpose of:

___Litigation

___Insurance

___Self/Personal Copy*

___Transfer or Continuity of Care

___Other _____

___Disability

___Work Comp

___Behavioral Health/ Substance Use

Subject to Fees

Date Range _____ to _____

- ❑ Physician Office Notes
- ❑ Immunizations
- ❑ Operative/Procedure Reports
- ❑ Other _____
- ❑ Cardiology/EKG Reports
- ❑ Lab/Path Reports
- ❑ Radiology
- ❑ Minimum Necessary

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules, including 42 C.F.R. Part 2. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

(Signature of Patient/Parent/Guardian or Authorized Representative) (Date)

This authorization will expire one year from the above date unless I specify an expiration date: _____

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4600 Valley Road, Lincoln, NE 68510 • Ph: (402) 483-4571 • Fax: (402) 483-5079

Authorization to Release Information to Family Members

Patient Name: _____Date of birth: _____

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information released to any family members, you must sign this form. Please note that this authorization will remain in effect until it is revoked in writing by the patient.

I authorize Lincoln Medical Education Partnership to disclose:

❑ My complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions

❑ My complete health record except for the following information

- ❑ Mental health records
- ❑ Communicable diseases including, but not limited to, HIV and AIDS
- ❑ Alcohol/drug abuse treatment records
- ❑ Other: _____

to the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Client or Legal Guardian Signature Date

Fee Agreement

I agree to pay Lincoln Medical Education Partnership (LMEP) for any services received (i.e., medical, behavioral health, acupuncture). I understand it is my responsibility to understand my health plan benefits.
Outstanding balances may be turned over to debt collection. This would result in dismissal from ALL LMEP services, including dismissal of ALL family members (spouse and children).
I hereby authorize all insurance benefits to be paid to LMEP and I understand that I am responsible for any claims not fully paid by my insurance carrier. I further authorize my provider to release any medical information necessary to process this claim. **UNLESS PREARRANGED, PAYMENT IS DUE 30 DAYS FROM DATE OF BILLING.**

Receipt of Notice of Privacy Practices Acknowledgment

I hereby acknowledge that I was offered a copy of LMEP's Notice of Privacy Practices (HIPAA), which sets forth the ways in which my personal health information may be used or disclosed by LMEP providers, and outlines my rights with respect to such information.

Informed Consent of Treatment

As a patient of LMEP, I am authorizing LMEP to provide services for **myself / my minor child or ward.**

I understand the potential risks, such as the discomfort of discussing problems and making changes. Necessary treatment includes, but is not limited to services, care, diagnostic procedures, medical treatments, pathology services, radiology services or behavioral health services as the provider deems necessary.
I understand that records of my care containing Protected Health Information may be used or disclosed to facilitate treatment, payment, and healthcare operations, and in other circumstances as authorized or required by law and described in the LMEP Notice of Privacy Practices.

- Nebraska state law requires some exceptions to privacy that are important to psychological care.
- All Nebraska citizens are required to report any reasonable belief that a child, or vulnerable adult, has been subjected to abuse or neglect.
- Healthcare providers are also obliged to act if a patient is in danger of self-harm or of harming another person.

I understand that I have certain rights to access my record and to authorize their release to others when such disclosure is in my best interest.

- If a patient is under the age of 18 (for counseling services) or 19 (for medical services), these rights usually belong to the parent or legal guardian. Because privacy is so important in this type of care, a provider may sometimes ask the parent or legal guardian to grant these privacy rights to the patient. However, all significant safety-related concerns will immediately be disclosed to the parent/guardian. If the patient is my minor child or ward, I will discuss my privacy rights with the provider, **I may agree or not agree** to grant these rights to the minor patient.

_____ _____
Printed Patient Name Date

_____ _____
Patient / Parent / Legal Guardian Signature Date

Code of Conduct

In keeping with LMEP's intent to provide a safe and healthy environment, we ask that you please follow the policies listed below:

- No smoking/vaping is allowed in the buildings or on any property of LMEP, including the parking lots.
- Weapons are not allowed on LMEP property regardless of whether or not the person is licensed to carry the weapon. Weapons include, but are not limited to, handguns, firearms, explosives, and any knife with a blade longer than three inches.
- The use and/or possession of alcohol and illegal drugs are prohibited on LMEP property.
- Clients are responsible for any prescription or OTC medication that are within their possession.
- I understand that the use of threatening, physical or verbal abuse towards any LMEP staff is grounds for immediate dismissal from ALL LMEP services, including dismissal of ALL family members (spouse and children). This may also result in contacting Law Enforcement if necessary. LMEP may also end the patient-provider relationship due to medication fraud or misuse, forgery, or if it's determined that the patient-provider relationship is not mutually beneficial to provide optimal health.

Attendance Policy

The professional staff of LMEP are dedicated to their patient's treatment and to empowering their patients to be self-reliant and accountable. Attendance is extremely important for one's treatment.

Patients for whom missing appointments, late arrivals and late cancellations has become a pattern will be discharged from ALL LMEP services. This will also include dismissal of your immediate family members (spouse and children). If this occurs, a list of referral sources for follow up treatment will be provided to you and your family. A pattern is considered three occurrences in a row or three occurrences out of four appointments.

A "no show" occurs when:

- The patient does not call to cancel their appointment and then fails to come to their appointment
- The patient arrives 15 minutes or later than the scheduled appointment time
- The patient fails to provide at least one hours' notice when cancelling the scheduled appointment

We understand that situations may arise that make it difficult to attend every appointment and to do so on time. However, we need this to be the exception rather than the rule.

I have read, understand and agree to LMEP's Attendance Policy as described above.

_____ _____

Printed Patient Name Date

_____ _____

Parent / Legal Guardian Signature Date

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