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 through 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.

NEW PATIENT DEMOGRAPHICS

Child's Information:

Name ____ Date of Birth _____________
LAST *FIRST* *MIDDLE INITIAL*

Legal Sex: ☐Male ☐Female Ethnicity: ☐Hispanic ☐Non-Hispanic Preferred Language:_________________

Race: ☐Caucasian ☐African-American ☐Native American ☐Asian Pacific Islander ☐Other______________

PRIMARY Parent/Guardian:

Last Name_________________________ First Name ______________________ Date of Birth _____________

Preferred Language _________________ Home Phone _________________ Cell Phone _________________

Address ____________________________________City _________________State _______ ZIP ___________

Relationship to the patient: ☐Mother ☐Father ☐Legal Guardian ☐Other:________________________

Does the child reside with this parent/guardian? ☐Yes ☐No

Can we sign you up for the Patient Portal? ☐Yes ☐No Email:____

OTHER Parent/Guardian:

Last Name__________________________ First Name ______________________ Date of Birth _____________

Preferred Language _________________ Home Phone _________________ Cell Phone _________________

Address (if different than Primary Contact):____

City _________________________State _________ ZIP _____________☐ Same address as Primary Contact

Relationship to the patient: ☐Mother ☐Father ☐Legal Guardian ☐Other:________________________

Does the child reside with this parent/guardian? ☐Yes ☐No

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

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	**Secondary Insurance Company**
Company Name:______________________________	Company Name:______________________________
Policy Holder Name:__________________________	Policy Holder Name:__________________________
Policy Holder DOB:___________________________	Policy Holder DOB:___________________________
Policy Holder SSN:___________________________	Policy Holder SSN:___________________________
Policy Number:______________________________	Policy Number:______________________________
Group Number:______________________________	Group Number:______________________________

Preferred Pharmacy (name & location) ____

Preferred Hospital ☐Bryan East (South 48th St) ☐Bryan West (South 16th St) ☐St. Elizabeth (South 70th St)

Other:____

Birth Information:

Where was your child born? (Please list name of hospital and town) ______________________________

Who delivered your child? ____

Route your child was born? ☐Vaginal Delivery ☐C-Section Birth weight: _____________________

Did your child require a stay in the NICU? ☐Yes ☐No

Any complications during or after pregnancy? ____

Has your child seen a dentist? ☐Yes ☐No If yes, dentist name:_________________________________

Who does your child live with? ____

____

____

Previous Provider(s)____ ☐Not Applicable

Pediatric Health Questionnaire:

Please list any previous hospitalizations: (include month/year and reason for hospitalization)

____

Please list any previous surgeries: (include month/year and surgery performed)

____

Please list any serious injuries or accidents: (include month/year and nature of injury or accident)

____

Does your child have any medical conditions you think we should know about?

____

Does your child have any drug or food allergies? ☐Yes ☐No (If yes, please list below with reaction)

____

Please list all of your child's medications, prescription and over the counter: (name of med and dosage)

____

____

Are your child's immunizations up to date? ☐Yes ☐No

Do you have a copy of your child's immunization records? ☐Yes ☐No

Where did your child get his/her immunizations? ____

Biological Family Health History – check all that apply

	Mom	Dad	Sibling 1	Sibling 2	Sibling 3	Sibling 4
Cancer						
Asthma						
Diabetes or other Endocrine Problems						
High Blood Pressure						
Heart Disease						
Bleeding Disorder						
Unexplained Sudden Death						

Other health concerns in family:____

____

____

lincoln medical education partnership

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

___Disability

___Work Comp

___Behavioral Health/ Substance Use

___Other ______________________________

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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Consent for Medical Treatment of Minor

The State of Nebraska requires that a person be 19 years of age or older before he or she can receive medical treatment without the consent of a parent or guardian. Exceptions to this rule include emergency treatments, treatment of sexually transmitted diseases and treatment of drug or alcohol abuse.

By signing this consent, you will be allowing, even in your absence, the health care providers of Lincoln Medical Education Partnership to treat your minor aged child for illness, injuries and preventative health care (including vaccinations) as we would do routinely in our office. For surgical procedures in our office, there is a separate consent form that must be signed.

I understand that this authorization will be in effect from the date signed unless revoked by me in writing.

Patient Name *(please print)*: ________________________________Date of Birth: ____________

Signature of Parent/Guardian: _____________________________________Date: ____________

Printed Name of Parent/Guardian: ____

Signature of Witness: ____ 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

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