Omaha Family Medicine, P.C.
Charles Stoner, M.D.

17841 Pierce Plaza
Omaha, NE 68130
(402) 991-7000 Fax: (402) 991-7999

Patient Information:

Name:______________________________ Date of Birth:______________
Last First Middle

Address:______________________________

City:______________ State:__________ Zip:__________

Home phone:______________ Cell phone:______________ Work phone:__________

SSN:______________ Sex: Male/Female Marital Status:__________

Email Address:______________________________

Preferred Method of Contact:______________________

Emergency Contact Name:______________________ Relationship to patient:__________

Emergency contact phone number:______________

Insurance policy Holder:

Name:______________________________

Primary Insured Date of Birth:______________ SSN:______________

Relationship to Patient:______________

I certify that I and/or my dependent(s), have insurance coverage with ______________________ and
Name of Insurance Company(ies)

assign directly to Dr. Stoner all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named physician may use my health care information and may disclose such information to the above named Insurance company(ies) and their agents for the purpose of obtaining payments for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______________________________ ______________
Signature of Patient, Parent, Guardian or Personal Representative Date

______________________________ ______________
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

PATIENT RECORD OF DISCLOSURES

I wish to be contacted in the following manner (check all that apply):

Home Telephone____

- O.K. to leave message with detailed information
- Leave message with call-back number only

Work Telephone____

- O.K. to leave a message with detailed information
- Leave message with call-back number only

Cell Phone____

- O.K. to leave message with detailed information
- Leave message with call-back number only
- O.K. to text with clinic appointment reminders
- O.K. to text our call-back number only

Written Communication____

- O.K. to mail to my home address
- O.K. to mail to my work/office address
- O.K. to fax to this number______________________________

Other____

Patient Signature______________________________Date____________

Print Name______________________________Birthdate____________

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402-991-7000

Office Services

Medical management services include evaluating new medical problems (ex: sinus infection, ankle sprain) or follow up of chronic medical problems (ex: diabetes, hypertension, high cholesterol). The fees are adjusted/reduced according to what your insurance company's allowable charges and are subject to copay, coinsurance and/or deductible.

Preventative services are covered by insurance 100% without copay. In an effort to promote good health, your insurance covers preventative services once a year to keep track of, recommend and coordinate appropriate services, such as immunizations, tests (ex: colonoscopy, mammogram, pap) and screening labs (ex: PSA, hepatitis C, cholesterol, blood sugar).

When both of these services are performed on the same visit you will see them on your explanation of benefits, even though your insurance company is responsible for the preventative services.

Name:______________________________ Date of birth:____________

Signature:__________________________________ Date:_____________

Omaha Family Medicine

RELEASE OF INFORMATION

I authorize the use or disclosure of my individual health information to the following person/persons listed below. I understand that the information used or disclosed pursuant to this authorization may be disclosed by the third party recipient and may be no longer protected by federal or state regulations.

NAME ______________________ RELATIONSHIP ______________________

NAME ______________________ RELATIONSHIP ______________________

NAME ______________________ RELATIONSHIP ______________________

OR

o Do Not Release any of my Personal Health Information to anyone else.

SIGNATURE______________________ DATE______________

CLINIC has secured authorization to release information as noted above.

Authorized Clinic Personnel Signature: ______________________

DATE: ______________

OMAHA FAMILY MEDICINE, PC

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE:________________

I acknowledge that I was offered a copy of the Omaha Family Medicine, PC. Notice of Privacy Practices.

________________________________ ________________________________
Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below.

________________________________ ________________________________
Personal Representative (Print) Personal Representative's Signature

Complete this section if this form is not signed and dated by the patient or patient's personal representative.

I have made a good faith effort to obtain a written acknowledgment of receipt of Omaha Family Medicine, PC. Notice of Privacy Practices but was unable to for the following reasons:

- ◯ Patient refused to sign
- ◯ Patient unable to sign
- ◯ Other ____

________________________________ __________________________
Employee Name Date

Omaha Family Medicine
Charles H Stoner, M.D.
Consent to Outpatient Services for

Authorization for Medical Treatment: I authorize the physician(s) or medical staff in charge of the care of this patient to administer any treatment as may be necessary or advisable in the diagnosis and treatment of this patient. This authorization includes, but is not limited to, routine diagnostic procedures, rehabilitation therapy, laboratory tests and x-rays. I acknowledge that no guarantees have been made to me as the results of my treatments, tests or procedures.

Assignment of Facility Benefits: I assign all benefits to Charles H Stoner, M.D. and authorize direct payment of all insurance benefits or Medicare/Medicaid benefits to which I may be entitled. This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits. It also specifically includes proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgement for person injuries caused by a third party. We agree to pay for any and all charges not paid pursuant to this agreement. A photocopy of this agreement shall be as valid as the original.

Statement of Responsibility: I understand that I am financially responsible to Charles H. Stoner, M.D. as the patient, parent, guardian, and conservator or insured for all charges not covered by the above assignment. Charges may include any medical insurance deductibles, co-insurance and copayments. I understand that to sign as a guarantor means that if the patient does not pay Charles H. Stoner, M.D. for all charges due, I, as a guarantor, will be responsible for such payment.

Non-covered Medicare Services: Medicare has certain outpatient procedures that are excluded form coverage including but not limited to those of routine diagnostic workups or routine physical examinations. If the patient's medical chart indicates that the patient's treatment is one for which no Medicare or Medicaid benefits are allowable, I understand that all charges incurred during treatment will be the patient's own financial responsibility. There are other limitations and charges for which the patient may be responsible; the patient will be provided additional information with regard to these charges and limitations on a separate written form.

Authorization to Release Information to Insurance Company/Third Party Payer: I authorize Charles H. Stoner, M.D. and any physician, therapist, practitioner, pharmacist or other person, any hospital, any medical service organization, any insurance company or any other institution or organization to release nay medical information about the patient necessary to determine benefits which may be payable for this treatment.

Authorization for Quality Review: I acknowledge that it may be appropriate for Charles H. Stoner, M.D. to review the overall care provided to patients prior to and following the patient's treatment. I understand that this review is for the sole purpose of maintaining and improving the overall quality of healthcare provided to Charles H. Stoner, M.D. patients. Therefore, I authorize the physicians and therapists and other healthcare professionals who cared for the patient at Omaha Family Medicine with copies of records regarding my care that pertain to the treating diagnosis as needed for quality review purposes. This consent is valid for the care provided to me for up to 12 months before and no longer than three months after my treatment at Omaha Family Medicine.

Personal Valuables: Charles H. Stoner, M.D. shall not be liable for the loss of or damage to any personal property.

Assignment of Benefits: I assign authorized payment to Charles H. Stoner, M.D., all insurance benefits or Medicare benefits to which we may be entitled. This assignment specifically includes, but is not limited to, major medical and disability insurance proceeds and benefits accruing under any settlement, structured or otherwise, or awarded in judgement for personal injuries caused by a third party. I agree to pay Charles H. Stoner, M.D. for any and all charges not paid pursuant to this agreement. A photocopy of this agreement shall be as valid as the original.

This undersigned certifies that he/she has read the foregoing or is the parent or is duly authorized by or on behalf of the patient to execute the above and accepts its terms.

______________________________ ______________________________

Patient's or Responsible Party's signature Date

______________________________ ______________________________

Responsible party's relationship to patient Witness

____

Reason patient unable to sign consent

Charles H. Stoner
17841 Pierce Plaza
Omaha, NE 68130
P: 991-7000 F: 99-7999

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-Payments and Deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contact with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-Covered Services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of Insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license before each visit and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claim Submission.** We will submit your health insurance claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. We do not file any third party liability cases, this will be your responsibility to file.

(OVER)

6. **Coverage Charges.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 46 days, the balance will automatically be billed to you.

7. **Nonpayment.** Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

____ ______________

Signature of patient or responsible party **Date**

MISSED APPOINTMENT POLICY

We want to thank you for choosing us as your health care provider. In order to give you and all our patients, the best possible care, we request that you review our policy regarding missed appointments. **A missed appointment is when you fail to show up for an allotted appointment time, without a phone call or cancellation notice of at least 24-hours.** Please remember that we have reserved appointment times especially for you. Therefore, we request at least a 24 hour notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients.

Your phone call is critical in helping us provide continuous care to all of our valued patients. Repeated missed appointments or late cancellations may result in discharge from the practice.

I have read and understand the policy stated above:

Signature____ Date______________________

Name______________________________

Date______________________________

Review of Systems Checklist

Are you *currently* experiencing any of these symptoms (Check all that apply)?

Respiratory:

__Spitting up blood
__Shortness of breath
__Asthma or wheezing
__Frequent coughin
__None in this category

Gastrointestinal:

__Stomach pain
__Blood in stool
__Change in bowel movements
__Nausea or vomiting
__Frequent diarrhea
__Constipation
__Painful bowel movements
__Loss of appetite
__None in this category

Skin and Breasts:

__Rash or itching
__Change in skin color
__Change in hair or nails
__Non-healing sores
__Chane in appearance of a mole
__Breast pain
__Breast lump
__Breast discharge
__None in this category

Mind/Stress:

__Nervousness
__Depression
__Sleep problems
__Memor loss or confusion
__None in this category

Heart and Cardiovascular:

__chest pain
__Sudden heartbeat changes
__Swelling of feet, ankels, hands
__Heart trouble
__None in this category

Women Only:

__Irregular periods
__Painful periods
__Vaginal discharge
__None in this category
Date of last menstrual period______________

Neurological:

__Frequent or recurrent headaches
__Light headed or dizzy
__Convulsions or seizures
__Numbness or tingling sensation
__Tremors
__Stroke
__Have you ever had a head injury
__Have you ever been in an auto accident
__None in this category

Genitourinary:

__Sexual difficulty
__Kidney stones
__Burning or painful urination
__Blood in urine
__Change in force or strain with urination
__incontinence or dribbling
__Frequent urination
__None in this category

Hematologic/Lymphatic:

__Swollen glands
__Easily bruise or bleed
__Anemia
__Phlebitis
Transfusion
__Slow to heal after cuts
__None in this category

General (constitutional):

__Recent weight change
__Fever
__Fatigue
__None in this category

Eyes and Vision

__Wear glasses/contact lenses
__Blurred/double vision
__Glaucoma
__Eye disease or injury
__None in this category

Endocrine:

__Thyroid problems
__Diabetes
__Excessive thirst or urination
__Cold extremities
__Heat or cold intolerance
__Change in hat or glove size
__Dry skin
__Glandular or hormone problem
__None in this category

Musculoskeletal:

__Joint stiffness or swelling
__Weakness of muscle or joints
__Muscle pain or cramps
__Muscle weakness
__Neck pain
__Upper or mid back pain
__Low back pain
__Joint pain
__Difficulty walking
__None in this category

Ears, Nose, Throat:

__Bleeding gums
__Bad breath or bad taste
__Sore throat or voice change
__Swollen glands in neck
__Mouth sores
__Ringing in the ears
__Earaches or drainage
__Sinus problems
__Nose bleeds
__hearing loss
__None in this category