NEBRASKA URBAN INDIAN MEDICAL CENTER **PATIENT INFORMATION**

PATIENT INFORMATION

LAST NAME		FIRST NAME		MI	
OTHER NAME (NICKNAME)		DOB		AGE	
SEX	MALE FEMALE	MARITAL STATUS	S M D W	SS#	
ADDRESS		CITY / ZIP			
PREFFERRED CONTACT PHONE #	☐ HOME ________ ☐ CELL ________ ☐ WORK ________ (PLEASE CHECK PREFERRED CONTACT NUMBER)				
RACE		ETHNICITY	HISPANIC / LATINO Y N	TRIBE	
PREFFERRED LANGUAGE	☐ ENGLISH ☐ SPANISH ☐ OTHER ________				
ARE YOU A VETERAN	YES NO	WHICH ARMED SERVICE:			

CONTACT INFORMATION FOR MINOR (18 AND UNDER)

MOTHER / GUARDIAN LAST NAME		FIRST NAME			
ADDRESS		CITY / ZIP			
DOB		SS#		EMPLOYER		EMAIL	
PREFFERRED CONTACT PHONE #	☐ HOME ________ ☐ CELL ________ ☐ WORK ________ (PLEASE CHECK PREFERRED CONTACT NUMBER)				
FATHER / GUARDIAN LAST NAME		FIRST NAME			
ADDRESS		CITY / ZIP			
DOB		SS#		EMPLOYER		EMAIL	
PREFFERRED CONTACT PHONE #	☐ HOME ________ ☐ CELL ________ ☐ WORK ________ (PLEASE CHECK PREFERRED CONTACT NUMBER)				
PATIENT LIVES WITH	☐ MOTHER ☐ FATHER ☐ BOTH ☐ OTHER ________				

ADDITIONAL HOUSEHOLD MEMBERS

NAME: ________ DOB: ________ RELATIONSHIP: ________

NAME: ________ DOB: ________ RELATIONSHIP: ________

*****(If additional space is needed , please use the back)**

INSURANCE INFORMATION

INSURANCE: ________ POLICY #: ________ GROUP #: ________

EMERGENCY CONTACT (someone outside the home)

NAME		PHONE		RELATIONSHIP	

The federal government requires us to provide health care services to our financially vulnerable communities, please write down how much you make yearly

$________ (if not sure just an approximate guess) ***Number of People in Household** ________

CONSENT FOR MEDICAL TREATMENT

By signing this document, I am giving my consent for medical evaluation, diagnosis, treatment, and/or care provided by staff of Nebraska Urban Indian Medical Center for myself, or as the agent or guardian for the patient listed above. I also understand I have the right to refuse any services offered.

RELEASE OF MEDICAL INFORMATION

By signing this document, I further verify the accuracy of the above information and I authorize the release of any medical information necessary to process any claims for payment of medical services. If the payer accepts assignment, I request and authorize the payments for this claim be made directly to the physician or supplier for the services. Furthermore, I consent to have medical information (excluding information regarding HIV testing or HIV results) exchange between Nebraska Urban Indian Medical Center and any referred physician ordered by my provider / physician.

SIGNATURE: ________ Relationship: ________ DATE: ________ CHART # ________

Nebraska Urban Indian Medical Center

Patient Consent for Use & Disclosure of Protected Health Information

I hereby give my consent for Nebraska Urban Indian Medical Center to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by Nebraska Urban Indian Medical Center describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Nebraska Urban Indian Medical Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Nebraska Urban Indian Medical Center Attn: Clinic Administrator, 2331 Fairfield Street, Lincoln, NE 68521.

With this consent, Nebraska Urban Indian Medical Center may call my home or other alternative locations and leave a message on voice mail, with a responsible party who answers the phone or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care.

With this consent, Nebraska Urban Indian Medical Center may mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.

With this consent, Nebraska Urban Indian Medical Center may e-mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements.

I have the right to request that Nebraska Urban Indian Medical Center restricts how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if does, it is bound by this agreement.

By signing this form, I am consenting to allow Nebraska Urban Indian Medical Center to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Nebraska Urban Indian Medical Center may decline to provide treatment to me.

☐ I have reviewed and received a copy of Notice of Privacy Practices.

Signature of Patient or Legal Guardian	Date	Relationship to Patient

Print Name of Patient	Print Name of Legal Guardian if Applicable

Patient/Guardian must be provided with a signed copy of this authorization form.

Nebraska Urban Indian Medical Center
2331 Fairfield Street
Lincoln, NE 68521

Dear Patient:

We welcome you as a new patient to our office and are pleased to extend to you every possible courtesy. To avoid billing and insurance problems, we would like to review with you the office policies of Nebraska Urban Indian Medical Center. Payment / Co-pays are expected as services are rendered. If for some reason this is not possible, please arrange to discuss this matter with the Clinic Administrator.

If you have health insurance, please read your policy, so you know your coverage. Our office will be happy to submit your claim to your health insurance company for whatever portion of your rendered services they will cover, although it is important that you realize **a portion or the entire fee may be your responsibility.** In some cases, insurance policies cover only a small portion of the total expenses. If you change insurance companies please NOTIFY OUR OFFICE.

Patient Authorization:
In order to submit a claim to your insurance carrier for services rendered, we must have the following authorization on file.

OTHER HEALTH INSURANCES
I authorize Nebraska Urban Indian Medical Center to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the Practice and authorize and direct my insurance carrier or its intermediaries to issue payment directly to Nebraska Urban Indian Medical Center for the covered services. I also authorize Nebraska Urban Indian Medical Center to furnish complete information to my insurance carrier or its intermediaries regarding services rendered.

I authorize Nebraska Urban Indian Medical Center to initiate a complaint to the insurance commissioner on my behalf for any reason.

My Signature affirms that I have read and received a copy of the Nebraska Urban Indian Medical Center Office Policies.

Signature: ______________________________ Date: ________________

MEDICARE ONLY
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization a claim to Medicare for payment.

Signature: ______________________________ Date: ________________

Release of Information

AUTHORIZATION FORM

I, ______________________________ hereby authorize the following individuals to make and/or cancel appointments on my behalf.

Name	Relationship	Phone #

I, ______________________________ hereby authorize the following individuals to speak on my behalf to any provider and/or NUIMC staff regarding my medical condition, including lab results, except for HIV results.

Name	Relationship	Phone #

☐ **I do not wish to give authorization at this time**

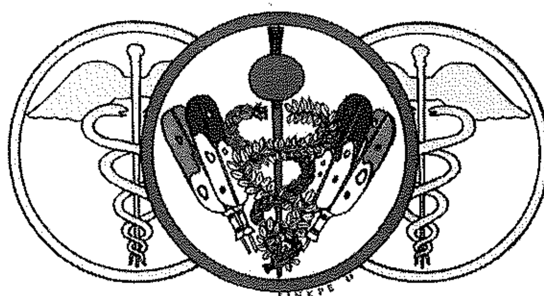
I hereby give authorization to Nebraska Urban Indian Medical Center staff to inform anyone who asks if I am at the clinic. Yes No

This authorization is valid for one year from date of signature.

I understand that any personal health information or other information released to the person(s) identified above may be subject to re-disclosure by such person(s) and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to the clinic administrator, prior to action being taken based on this request.

Patient Signature: ____________________________ Date: ______________



Nebraska Urban Indian Medical Center

Cancellation/Late Arrival Policy

Patient Name ________________________ **Date of Birth** ________ **Chart #**______

At Nebraska Urban Indian Medical Center we value your time, it is our goal to serve our patients in a timely manner. To do so we ask that you help us by arriving on time or giving us notice when you can't keep your appointment. This allows us to remain on schedule and honor the time commitments of all our patients, and to open cancelled appointments to patients who need to be seen.

Late Arrivals: If you arrive 5 minutes late for your scheduled appointment you will be asked to reschedule your appointment.

No Show: it is important for scheduling purposes that you call and inform our office if you are going to miss your appointment. In order to treat our patients effectively, we ask that you contact our office 2 hours prior to your scheduled appointment to cancel or reschedule. If you fail to contact our office your appointment will be considered a No Show, upon 3 no shows you will not be eligible to schedule an appointment for 3 months.
In addition, refills of your medications will only be available for the first 30 days.

Patient Signature________________________________ **Date**_______________

Nebraska Urban Indian Medical Center
Policy and Procedure Manual

Patient Care Policy

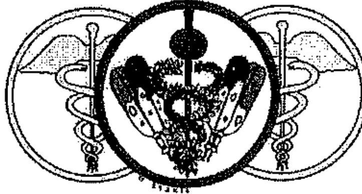
No Show for Clinic Appointment Policy

Policy

It is the policy of Nebraska Urban Indian Medical Center that patients are responsible for keeping appointments they have scheduled.

Procedure

1. NUIMC staff will place reminder phone call to patients one day prior to their scheduled appointment. If patient cannot be reached by phone a message will be left regarding their appointment.
    A. Patients who are signed up with our texting service will get a text message the day before their scheduled appointment. Patients must reply to the text message to confirm the appointment or call our office to cancel or reschedule the appointment.
    B. Not replying to text message or calling our office up to 2 hours prior to your appointment will result in a No Show.
2. It is the patient's responsibility to provide NUIMC with their most current contact information.
3. If the patient must cancel the appointment, the cancellation notice must be given 2 hours prior to scheduled appointment time.
4. Upon a 3rd No Show the patient will not be eligible to schedule an appointment for 3 months as of the last No Show date.
    A. A letter will be mailed to patient to inform them of their No Show. A 3rd No Show letter will inform patient that they will not be able to schedule an appointment for 3 months as of their last now show date.
    B. Medication refills will be authorized for 30 days from the date of the 3rd letter, but will not extend beyond that 30 day period.
    C. If a patient no shows a Same Day Appointment they will not be able to schedule another Same Day Appointment for the next 3 months. Patient will be verbally informed of this at the time of scheduling.
5. Patients must sign Cancellation/No Show Policy, a copy of this policy will be provided upon request.



Opioid Guideline Consent Form

Nebraska Urban Indian Medical Center's goal is to give patients the best and safest care. Today about 192 deaths happen each day due to overdoses from prescription opioids. NUIMC follows CDC guidelines for prescribing opioids, thus reducing the risk of opioid use disorder, overdose, and death.

If you are a patient that is being treated with opioids for chronic pain, you can expect your provider to review your treatment plan at your next visit.

This review may include:

- Establishing goals
- Discussion of the risks and benefits of narcotic use for chronic pain management.
- Evaluating effectiveness and/or risks of current chronic treatment plan.
- Consideration of non-narcotic treatment options for chronic pain.

As your healthcare provider, we are a partner in your health. We are committed to giving you the safest and most effective care.

Patient Name ______________________________ Chart Number ______________

Patient Signature ____________________________ Date __________________