



5625 S 62nd St Suite 100
Lincoln NE 68516
Phone: (402)489-3834
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AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Consent for patients age 19 and Older

Once a patient reaches the age of majority (age 19 in the state of Nebraska), we are required by law to protect their health information and may not share it with parents or others without the patient's written permission.

Patient Information:

Name: _____ DOB: _____

Phone Number: _____ Email: _____

Authorized Individuals

I authorize Lincoln Pediatric Group, their physicians, nurses, and other personnel ("Health Care Providers") to disclose my protected health information to the following individuals:

NAME	Phone Number	Relationship
_____	_____	☐ Parent ☐ Guardian ☐ Other: _____
_____	_____	☐ Parent ☐ Guardian ☐ Other: _____
_____	_____	☐ Parent ☐ Guardian ☐ Other: _____

Information that may be shared:

(check all that apply)

- ☐ Appointment scheduling and reminder
- ☐ Billing and insurance information
- ☐ Medical records and visit summaries
- ☐ Test results and lab reports
- ☐ Immunization records
- ☐ Care coordination and treatment discussions
- ☐ All health information maintained by the practice

Method of Disclosure: (check all that apply)

- ☐ Verbal communication
- ☐ Written records
- ☐ Electronic records / Patient portal access

Patient's Signature: _____ Date: _____

This authorization will remain in effect until:

- ☐ This date: _____
- ☐ I revoke it in writing

I understand that I may revoke this authorization at any time by submitting a written request to Lincoln Pediatric Group. Revocation will not apply to information already disclosed.

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

LINCOLN PEDIATRIC GROUP, LLC
FINANCIAL POLICY

(To be used only by patients 19 years of age and older)

Patient name (print)

Date

In the event that your parent/guardian stops assuming financial responsibility for your account, you understand and agree to the following:

If you do not have insurance, payment is due at the time services are rendered unless alternate payment arrangements are made with our billing staff. To assist you, we accept cash, checks, MasterCard or Visa.

If you have insurance, we will file your primary and secondary insurance for you as a courtesy if you have provided us with your current insurance information, and if you have authorized your insurance company to pay us directly. **You must realize, however, that your insurance is a contract between you and your insurance company. Payment to us is your responsibility.** If, at the end of ninety days, your insurance company hasn't remitted payment to us, payment will be due in full from you. If your insurance company requires co-payments or deductibles as a part of your plan, these payments are collected upon check-in. If a service is not a covered benefit in your insurance plan, you are responsible for the payment to us.

We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account. A finance charge of 1% per month is added to all overdue accounts. There is a service charge of \$15.00 for each returned check. We do use outside agencies as a means of collection should we deem it necessary.

The person signing this financial policy is responsible for any and all payments for services. Any legal agreement, or other disagreement, between two parties as it relates to payment for our services must be dealt with between those parties and does not involve Lincoln Pediatric Group, LLC.

If you have any questions about the above information, please call (402) 489-3834 and ask for someone in the billing department. We are here to help you.

AUTHORIZATION: I have read and agree to the terms and conditions listed above. I hereby authorize the release of any medical information necessary to process my health insurance claim(s) and authorize payment of benefits directly to Lincoln Pediatric Group, LLC. I understand I am financially responsible to Lincoln Pediatric Group, LLC for charges not covered or denied by my insurance company. I further agree to pay the cost of collection, court costs, and other reasonable fees should they be required in the event of my nonpayment. I understand and agree that any cellular or land line phone numbers and email addresses provided to this office and to any of our service providers, now and in the future, may be used as a means to contact me, and this office and our service providers may leave messages for me manually and by using automatic systems such as by artificial or prerecorded voice or text and disclose the nature of the communication.

Signature of Patient: _____

Date: _____