LINCOLN INTERNAL MEDICINE

NEW PATIENT APPLICATION

We are accepting new patients on a limited basis. Please provide us with the following information and FAX it to us at (402) 423-0739. We will review your information and contact you by email notifying you if we accepted you as a new patient in our practice or if we are unable to accept you as a new patient at this time.

General Patient Information

Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City, State: _____ Zip Code: _____

Date of Birth: _____ Email Address (Required): _____

Home/Cell Number: _____ Work Number: _____

****PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF INSURANCE CARDS****

Primary Insurance Name: _____ Insurance Number: _____

Preferred Physician: _____ Ok to check with other physicians? Yes or No

Who referred you to us: _____

Previous primary care provider/clinic: _____

Reason for switching from Previous Provider: _____

Medical History

Please indicate your past medical history: _____

_____

_____

Please list all current medications: _____

_____

_____

Please indicate all your past hospitalizations and the reason: _____

_____

_____

Please list all past surgeries: _____

_____

_____

I acknowledge that the information on this application is true and correct to the best of my knowledge

Signature: _____ Date: _____

Records to be sent to:
Lincoln Internal Medicine
3901 Pine Lake Rd, Suite 220
Lincoln, NE 68516
Phone: 402-421-3240
FAX: 402-423-0739

LINCOLN INTERNAL MEDICINE

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT INFORMATION: Please Print Clearly Patient ID #: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Other Name(s) Used: _____ Date of Birth: _____ Phone#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Practice of Where Records Reside

Name of practice: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone#: _____ Fax #: _____

****Please only list one location per form. Please fill out a separate form for each practice location request.**

Specific information to be disclosed:

☐ Medical Records from date _____ to date _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records , insurance records, and records received from other healthcare providers. (LAST 2 YEARS ONLY)

☐ Most Recent: Mammogram, Pap, Colonoscopy, DM Eye / Foot Exams, Recent Procedures

☐ Other: _____

Reason for Release of Information: (*Please mark all that apply*)

Treatment/Continuing Medical Care: ____ Employment: ____

Personal Use: ____ Legal Purposes: ____ Other (Specify): ____

School: ____ Insurance: ____ Disability Determination: ____

Include: (*Indicate by Initialing*)

Drug, Alcohol, or Substance Abuse Records _____

Mental Health Records *(Except Psych Notes)* _____

HIV/AIDS-Related Information _____
(Including HIV/AIDS Test Results)

Genetic Information _____
(With Genetic Test Results)

The individual signing this form agrees and acknowledges as follows:

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month: _____ Day: _____ Year: _____

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL,** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION,** except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION,** and **GENETIC INFORMATION,** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize the release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.
THIS FORM IS INVALID IF ANY OF THE ABOVE SECTIONS ARE NOT MARKED AND SIGNED.

_____
Patient Signature Date

_____
Parent or Legal Guardian if Minor Date

Witness (optional): _____ Date: _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment. Signature of Minor (if applicable): _____ Date: _____