Sancta Familia Medical Apostolate
10506 Burt Circle
Omaha, NE 68114
Phone: (402) 991-3393
Fax: (402) 991-3390

Patient Information

Last Name __________________________________ **First Name**__________________________________ **Middle Initial** ____

Date of Birth ___/____/____ **Social Security #** _______-_______-_______

Gender ☐ Male ☐ Female **Language Preference** ____________________________________

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino **Race** _______________________________

Street Address ____ **State**____________ **Zip Code** ______________

Home Phone _____-_____-_____ **Cell Phone**_____-_____-_____ **Preference** ☐ Home ☐ Cell

Email Address ____

Emergency Contact Information

Primary

Name_________________________________ Relationship___________________________ Contact Phone # _____-_____-_____

Secondary
Name_________________________________ Relationship___________________________ Contact Phone # _____-_____-_____

Responsible Party Information

Last Name _______________________________ **First Name**____________________________________ **Middle Initial** ____

Date of Birth ____/____/____ **Gender** ☐ Male ☐ Female

Street Address ____ **State**__________ **Zip Code** ____________

Home Phone _____-_____-_____ **Cell Phone**_____-_____-_____

Primary Insurance Information

Insurance Company Name ____________________________ **Policy No.** ___________________**Group No.** ______________

Medical Claims Address __________________________________ **State**_________ **Zip Code**_____________

Patient's Relationship to Subscriber _________________________________

Secondary Insurance Information

Insurance Company Name ____________________________ **Policy No.** ___________________**Group No.** _______________

Medical Claims Address __________________________________ **State**_________ **Zip Code**_____________

Patient's Relationship to Subscriber _________________________________

Consent: I hereby authorize treatment of the above name patient and agree to pay all charges for treatment regardless of insurance coverage or the pendency of insurance claims. I authorize the release of all medical information pertinent to my medical care and necessary to process my insurance claims. I will assign all medical benefits to Sancta Familia Medical Apostolate. A photocopy of this form shall be as valid as the original. I understand that I can withdraw this medical consent at any time by notifying this office in writing. I have read this information thoroughly and understand it.

Patient Signature ____ **Date** ___________________

Witness (Employee of SFMA) __________________________________ **Date** ___________________

New Adult Patient Medical Intake Form
Your medical information is important. Please take time to fill out this sheet. You may write “None” or “N/A” if needed. All information is confidential.

Name:	DOB:	Date:

How did you hear about Sancta Familia?
____

MARITAL STATUS:
Single Married Divorced Widowed Separated N/A

RELIGIOUS AFFILIATION: ____

OCCUPATION: ____

EDUCATION: ____

ADVANCE DIRECTIVES: ☐ None ☐ FULL CODE or ☐ DO NOT RESUSCITATE

POWER OF ATTORNEY: ____
(Please provide a copy of any Living Will or Power of Attorney documents available.)

MEDICATION ALLERGIES? ____

Reaction: (rash/hives/shortness of breath) ________________________________

PRESENT MEDICATIONS, SUPPLEMENTS, OR HERBALS AND THEIR DOSAGE

Medication	**Dose**	**Reason for Medication**

PREFERRED PHARMACY: ____

EXERCISE HABITS: ____

HOBBIES: ____

ENVIRONMENTAL/OCCUPATIONAL EXPOSURES (ex. loud noise, chemicals)
____

TRAVEL OUTSIDE THE USA: (year/location) ________________________________

ALCOHOL USE: ☐ Never
☐ Yes Year Started _____ Year Quit _____
Current Number of Drinks ____per day/ week /month

TOBACCO USE: ☐ Never
☐ Yes Year Started _____ Year Quit _____ Packs per day _____

CAFFEINE USE: ☐ Never
☐ Yes Type (soda, coffee) Number of drinks ____ per day/week/month

DRUG USE: ☐ Never ☐ Previous/Current: Marijuana Cocaine Methamphetamines
Other_____________________
IV Drug Use: ☐ Never ☐ Previous/Current _________________

INCARCERATION HISTORY: ☐Never ☐ Previous/Current ______________

SURGICAL PROCEDURES, HOSPITILAZATIONS, PREVIOUS INJURIES

DATE	REASON	LOCATION

Please indicate when you last had the following done or answer "N/A" if not done before.

	DATE	LOCATION
Colonoscopy		

DIABETICS ONLY

	DATE	LOCATION
Diabetic eye exam		
A1c Check		
Urine Protein Exam		

WOMEN ONLY

	DATE	LOCATION
Pap Smear		
History of Abnormal Pap	☐ Yes ☐ No ☐ Unsure	
Mammogram		
Menstrual Period		
Number of Pregnancies		
Number of Living Children	Term: ______ Premature______	
Number of Miscarriages		
Number of Abortions		

OTHER CONCERNS:

____

____

PERSONAL AND FAMILY HISTORY:

☐ Mark here if you were adopted or if your family history is unknown

**For Grandparents use "P" for paternal and "M" for maternal
i.e. PGM = paternal grandmother**

Check those that apply	Yourself	Mother	Father	Grandparents**	Brother	Sister	Children
Alcoholism/Addictions							
Allergies							
Alzheimer's							
Anemia							
Anxiety							
Arthritis							
Asthma							
Autoimmune disorder							
Bleeding disorder							
Cancer (Include Type) (include age of diagnosis)							
COPD/emphysema							
Coronary artery disease							
Depression							
Diabetes (Include Type)							
Eczema							
Epilepsy							
Genetic Disorder (Include Type)							
Gout							
Headaches							
Heart attack (include age of diagnosis)							
Heart disease (include age of diagnosis)							
Hepatitis (Include Type)							
High Blood Pressure							
High Cholesterol							
HIV/AIDS							
Hyperthyroidism							
Hypothyroidism							
Inflammatory Bowel Disease (Crohn's, etc)							
Kidney disease							
Liver disease							
Mental illness (Include Type)							
Migraines							
Stroke							
Tuberculosis							
Ulcers							
Other:							

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CONSENT FOR TREATMENT and FINANCIAL RESPONSIBILITY

I agree to pay The Sancta Familia Medical Apostolate for all services it provides to either myself, spouse, child(ren), and/or dependents. If I am unable to pay the entire bill for services provided, I understand I am expected to contact the billing department (at 402-978-5154) to discuss a payment plan. (The Sancta Familia Medical Apostolate does not receive funding from any other organization, such as the US government or religious entities.) **If I do not either pay the entire patient liable balance or at least setup a payment plan towards resolving the outstanding balance, future appointments may not be scheduled. If I default on my payment plan, I understand that an external collection agency will then monitor/collect balances.**

APPOINTMENT COURTESY

In the event that I am unable to arrive for my scheduled appointment, I will call the office at (402) 991-3393, at least 2 hours prior to the appointment time to notify them, otherwise a $25.00 appointment no show fee will automatically be added to my account. If you call within 24 hours of missing an appointment and rebook a new appointment, the fee may be waived.

TELEPHONE CONSULATION

Additional charges may be incurred for a phone consultation during which the provider makes a medical assessment in lieu of a clinic visit.

INSURANCE AND LABORATORY COVERAGE

I understand it is my responsibility to contact my insurance company to ensure that The Sancta Familia Medical Apostolate providers (TIN 27-3295657) are IN-NETWORK. Health Insurance policies are contracted by the patient, guarantor, or employer for the covered care, co-pay, and deductibles. I recognize that all covered services is a contract between myself, the insured, and the insurance company. The Sancta Familia Medical Apostolate cannot retrieve information about covered services within my policy beyond the policy plan, policy number, and co-pay, nor can they guarantee coverage for said services. Some insurance policies require a written referral from my primary care provider for special services. If I do not have that referral, I accept financial responsibility for the services provided to me. **I understand that in-house laboratory tests will be billed directly by The Sancta Familia Medical Apostolate. I understand that all other laboratory tests will be billed separately by Physician's Laboratory PC. If I am required to use a different laboratory provider, it is my responsibility to inform The Sancta Familia Medical Apostolate prior to services.**

ASSIGNMENT OF BENEFITS

I hereby assign The Sancta Familia Medical Apostolate any insurance or other third-party benefits available for health care services provided to those listed below. If assigned benefits are not paid directly to The Sancta Familia Medical Apostolate, I agree to forward them all health insurance and other third-party payments I receive, immediately upon receipt.

MEDICARE/MEDICAID BENEFITS

I certify that Medicare/Medicaid eligibility given by me is correct. I authorize any holder of medical or other information about me to release to Medicare, its intermediaries or carriers, any information needed for this or related Medicare/Medicaid claims. I request that authorized benefits be paid on my behalf.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize The Sancta Familia Medical Apostolate to release all medical information requested by my health insurance carrier, Medicare/Medicaid, or any other third-party payer. I further authorize release of all or any part of the denoted family member or dependent's medical information to any health care provider who may require such medical information in connection with my current or subsequent health care and any person or entity, which may be responsible to pay any portion of charges incurred. I authorize contact with my insurance company or health plan administrator to obtain all pertinent financial information concerning coverage and payments under my policy and direct said insurance company or health plan administrator to release such information to The Sancta Familia Medical Apostolate. A photocopy of this release shall be considered valid.

I AGREE THAT THE PROVISIONS ABOVE WILL REMAIN IN EFFECT FOR MYSELF AND ALL LISTED PERSONS UNTIL I PROVIDE WRITTEN REVOCATION TO THE SANCTA FAMILIA MEDICAL APOSTOLATE.

I hereby request and consent for medical care * for the patient(s) listed below.

Patient's Name: ____ DOB: __________________

Signed ____ Date: ____________________________
(Patient, Parent, legal guardian or authorized representative-*Please denote relationship to patient)*

Witness __________________________________ Date: _____________
**Witness must be a member of the staff employed in The Sancta Familia Medical Apostolate office*

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Notice of Privacy Practices Receipt & Permission to Disclose Protected Health Information

This notice describes how medical/protected health information about you may be used and disclosed. Please read this carefully. This form is to accompany the Notice of Privacy Practices.

Summary: As a patient you:
1. Can inspect and copy your health information. 2. Can request corrections to your health information.
3. Can request that your information be restricted. 4. Can request confidential communication.
5. Can obtain a report of disclosures of your information. 6. Can obtain a paper copy of this notice.

We want to help assure you that your medical/protected health information (PHI) is secure. This notice contains information about how we will help ensure that your information remains private.

Disclosing health information:

Your personal health information may be disclosed to necessary parties to provide for treatment, payment and health care operations. You may also authorize release to family members or other persons.

Patient's Name (please print)____________________________________ DOB:______________

Persons to whom information may be disclosed:
Name: _____________________ Relationship: ___________ Phone#:____________

Name: _____________________ Relationship: ___________ Phone#:____________

Receiving health information:

Please indicate the phone number that you wish to be used for receiving calls about your appointments, lab and testing results, and other health information. Be aware that a cell phone number is not considered a secure and private line. You may list both a cell and home if you wish.
Phone number(s): ____

___ Yes, you may leave confidential detailed messages on my telephone voicemail listed above.

___ Yes, you may leave a message for a returned call.

___ No, you may NOT leave confidential detailed messages on my telephone voicemail listed above.

I acknowledge that I was provided with the Notice of Privacy Practices of Sancta Familia Medical Clinic.

____ __________________ ________
Signature of patient/ legal guardian if under 19 years Relationship Date

*This authorization is effective until a written request from the patient is submitted, revoking authority.

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Request for Access to Medical Records

Notice to Patient: You may use this form to request to inspect or copy information maintained about you. This type of request is described in our Practice's Notice of Privacy Practices. To revoke this request provide a written notice to our office.

Patient Name ____ **Date of Birth** _________________

Please FAX a copy of my records to Sancta Familia Medical Apostolate.

Doctor Name ____

Name and Location ____

____

Phone ____________________________ **Fax** __________________________________

Please send the following health information:

( ) **Complete Medical Record**

( ) **Medical Records from** ___________ **to** __________
Date Date

( ) **Specific Records Listed:** ____

If applicable, include, health information related to testing, diagnosis, and/or treatment of (initial applicable line): ________ HIV (AIDS) _______ Sexually Transmitted Diseases

________ Mental Health _______ Drug and/or Alcohol Abuse

Patient Name Print ____

Patient Signature ____ **Date:** ______________________

For Personal Representative of Patient or To Access Patient Information
I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above or the Patient has requested that I can receive medical information.

Print Representative Name ____

Relationship ____

Signature of Representative ____ **Date:** _______________