



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 _____



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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 CONSULTATION

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*

Sancta Familia Medical Clinic

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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:** _____