UNO Health Center Demographics Form

PATIENT DEMOGRAPHICS

Legal Name (LAST / FIRST / INITIAL)				Preferred Name
Date of Birth	Sex	Pronouns	Social Security Number	Student ID Number
Address		City	State	Zip Code
Email				
Home Phone Number	Mobile Number		Work Number	

Appointment Reminder Preference

- ☐ Text reminder
- ☐ Phone call
- ☐ Email reminder

GENERAL INFORMATION

Need an interpreter? ☐ Yes ☐ No	Preferred Language	Marital Status	Race	Ethnicity

EMERGENCY CONTACT

Name		Relationship	
Primary Phone Number	☐ Home ☐ Mobile ☐ Work	Needs an interpreter? ☐ Yes ☐ No	Preferred Language

PRIMARY CARE PROVIDER

Provider Name	Address		
Phone Number	City	State	Zip Code

EMPLOYER

Employer Name	Employment Status		
Address	City	State	Zip Code

GUARANTOR INFORMATION *(person responsible for the bill if patient is under 19 years old)*

Name		Relationship		
Primary Phone Number ☐ Home ☐ Mobile ☐ Work		Date of Birth	Social Security Number	
Address		City	State	Zip Code
Employer Name	Employment Address		Employment Status	

PT NAME

MR #

ACCT #

1. CONSENT TO TREATMENT

As a patient of The Nebraska Medical Center, Bellevue Medical Center, and/or UNMC Physicians each individually and collectively doing business as Nebraska Medicine (“The Organization(s)”), I agree, request, and authorize attending physicians, their assistants or designees, and/or allied health professionals to administer such treatment to the patient as is necessary. Necessary treatment includes but is not limited to services, care, diagnostic procedures, medical treatments, pathology services, and radiology services as the physician(s) or other health care provider(s) deems reasonable and necessary. Necessary treatment may be provided via telehealth related technology or equipment. I have the right to refuse treatment via telehealth technology or equipment without affecting my future care or treatment. I acknowledge that no guarantees have been made to me as to the results of diagnosis, treatments, tests, or examinations.

I understand The Organization(s) has a process for assessing medically futile treatment, which in some instances may conflict with my wishes as expressed via an advanced medical directive or through a surrogate decision maker. In such rare circumstances my surrogate decision maker or I will be given the option of pursuing transfer to another physician or facility.

2. ASSIGNMENT OF INSURANCE BENEFITS

a. 1. I assign to The Organization(s), subject to acceptance, all right, title, and interest in and to benefits payable, and authorize direct payments to The Organization(s), of all my health insurance benefits or benefits from any other third party payor. I also assign to The Organization(s) any and all claims and causes of action of any kind whatsoever that I may have against an insurance company or other third party payor (including an individual or group health plan) or against any other person or entity related to the payment or reimbursement for goods or services provided by The Organization(s), including any breach of fiduciary duty related to such payment or reimbursement. **I agree to pay The Organization(s) for all charges not paid pursuant to this assignment.**

2. I assign to clinics, individual physicians and physician group practices, and allied health professionals providing services in connection with the episode(s) of treatment to which this form applies, subject to acceptance, all right, title, and interest in and to benefits payable, and authorize direct payment to such clinics, individual physicians and physician group practices, and allied health professionals, of all my health insurance benefits. I agree to pay for charges not paid pursuant to this assignment.

3. I understand that I may receive separate billings from The Organization(s) and such clinics, individual physicians, physician group practices, and allied health professionals concerning their respective services rendered.

b. I agree that in the event a patient credit balance results from patient and/or responsible party payments under this Assignment, The Organization(s) may apply this patient credit balance to any other accounts for which I am financially responsible.

c. I agree that, by signing as the patient and/or responsible party, in consideration of the services rendered to the patient, I obligate myself and/or the patient to pay the accounts of The Organization(s), the attending physician, any consulting physician, and any allied health professional (whether such physicians are allied health professionals, employed by The Organization(s), independent practitioners, or members of group practices) in accordance with the approved charges as determined by Medicare and other third party payors, with the understanding that the patient and/or responsible party shall pay any deductible and co-insurance amounts together with any charges for professional services not covered by any such third party payors.

d. I agree that I am responsible for obtaining any prior authorizations or utilization review approvals required by my insurance company.

e. I understand any communications concerning disputed debts are to be sent to Executive Director, Revenue Cycle, Nebraska Medicine, 988140 Nebraska Medical Center, Omaha, Nebraska 68198-8140. Any attempt to settle the debt for less than the amount owed shall only be considered entered into if the Executive Director has agreed in writing to such settlement amount. I understand that if the Executive Director has not agreed in writing to such settlement, the Hospital has not intentionally discharged any debt, and I am fully responsible for payment of any remaining outstanding payment obligation owed for treatment.

3. FINANCIAL AGREEMENT AND RELEASE

a. I grant The Organization(s) or its designee permission to obtain a credit rating report, if necessary.

b. The Organization(s) may prepare bills for amounts up to and including an account’s total amount due on a regular basis.

c. I understand that patient liability will differ based upon each individual patient’s private insurance coverage or lack thereof.

d. I understand that I may request and will be provided with information on financial assistance programs.

e. I understand and agree that The Organization(s) shall not be liable for the loss or damage to my personal property.

4. AUTHORIZATION FOR RELEASE OF APPOINTMENT INFORMATION

I authorize The Organization(s) to release my name and appointment location to interested parties making inquiry. I understand I have the right to request that no information be released about me. All patient information is maintained in a confidential manner.

5. MEDICARE PATIENT’S CERTIFICATION

Patient Hospital Certification, Authorization to Release Information and Payment Request:

a. I certify that the information given in applying for payment under Title XVIII of The Social Security Act is correct.

b. I authorize release to the Centers for Medicare and Medicaid Services or its intermediaries any information needed for this or a related Medicare claim and request the payment of authorized benefits be made on my behalf.

c. I authorize any of The Organization(s) based physicians to submit a claim to Medicare or The Organization(s) to submit a claim on behalf of The Organization(s) based physicians with the understanding that I will be responsible for the entire unreimbursed balance of the claim to the extent permitted by law.

d. The actual co-insurance amount for hospital services will vary, however the amount is approximately 20% of the amount Medicare will pay the hospital for each individual service. No co-payment for a single service can be more than the amount of the Part A hospital deductible (see “Medicare and You Guide”). If I, as the patient, receive numerous services, the maximum co-payment amount for hospital outpatient services may exceed the Part A hospital deductible.

e. I certify that I have read the Conditions of Treatment form in its entirety and understand that other items and/or services may affect reimbursement under the Medicare program.

f. I (a) HAVE (b) HAVE NOT been in a hospital or nursing home within the past 60 days.
If (a) circled given name of Hospital or Home: ______________________________

Length of Stay: ______________________________

6. LEGAL RELATIONSHIP BETWEEN THE ORGANIZATION(S) AND PHYSICIAN

I understand that physicians providing services including radiology, pathology, anesthesiology, and emergency medicine services at The Nebraska Medical Center and at Bellevue Medical Center facilities are independent contractors with the patient and are not employees or agents of either of these facilities. As such, these various independent contractors may submit bills for the professional services they provide separate from the bill The Organization(s) may submit for technical services. Services provided by The Nebraska Medical Center and Bellevue Medical Center personnel are rendered to the patient pursuant to the general and special instructions of the patient’s attending and consulting physicians / surgeons as described above.

PT NAME

MR #

ACCT #

7. NOTICE OF PRIVACY PRACTICES (mark one below).

a. _______ I have received the Notice of Privacy Practices of The Organization(s).
b. _______ I have received the Notice of Privacy Practices of The Organization(s) at previous visit.
c. _______ I have NOT received the Notice of Privacy Practices of The Organization(s).

For Office Use Only Both i. and ii. to be completed by patient registration personnel.

i. Reason: ____________________
ii. Describe good faith effort to obtain acknowledgement: ____________________

8. RESEARCH

a. Nebraska Medicine is a research institution. As such, my patient records may be used for research with the approval of an Institutional Review Board (IRB), as required by and in accordance with federal regulations.

b. Samples of my blood, other bodily fluids, and tissues may be collected for testing as part of my healthcare at Nebraska Medicine. There may be some portions of my samples that are not needed for my healthcare tests. If I give my permission below, these samples could be used by researchers, with the approval of the IRB, as required by and in accordance with federal regulations.

This research may include the study of genetic material (DNA) or other information in my samples that may identify risks for specific diseases. Depending on the research, some of my genetic and health information may be placed into a scientific database for other researchers to use. Access to my identity and to my specific information will be carefully controlled.

By consenting to allow my leftover samples to be used by researchers, I acknowledge there are no plans to compensate me if this research results in discoveries that have commercial value.

☐ **I want my leftover samples to be used for research.** ______ **(staff initials)**

☐ **I DO NOT want my leftover samples to be used for research.** ______ **(staff initials)**

c. Research Recruitment Program
Based on information in my medical record, I may qualify to participate in research studies. Participation in any study is completely voluntary.

☐ **I agree to allow my records to be reviewed so that I may be contacted about research studies for which I may be eligible.** ______ **(staff initials)**

☐ **I DO NOT want to allow my records to be reviewed or to be contacted about research studies.** ______ **(staff initials)**

d. Questions? Change My Mind?
The choices I make about research in this form will remain in effect until I change them. If I have questions or later wish to change my designation for either the leftover sample research or the research recruitment program, I can call the Research Subject Advocate office at **402-559-6941**. A decision not to participate will not affect my care.

9. ELECTRONIC HEALTH INFORMATION EXCHANGE PARTICIPATION (mark one below)

a. _______ I have received the Electronic Health Information Exchange brochure.
b. _______ I have received the Electronic Health Information Exchange brochure at a previous visit.

I understand that should I not want my health information included in the Electronic Health Information Exchanges, I must follow the instructions in the brochure provided to opt out. I understand that by taking no action, my health information will be included in the Electronic Health Information Exchanges.

______ **(staff initials)**

10. DURATION

I understand the elections I have made on this form and the consent I am attesting to is valid for a period of one year from the date of my signature unless sooner revoked by me in writing except for the elections related to Research and the Electronic Health Information Exchange, which will remain valid unless and until I change my designation in the manner described above.

11. I ACKNOWLEDGE RECEIPT OF THE ORGANIZATION(S) PATIENT RIGHTS AND RESPONSIBILITIES.

The undersigned certifies that he/she has read the foregoing, and as the patient, or as duly authorized signer on behalf of patient, is authorized to execute the above and accept its terms. A copy of this document will be provided to patient or signer upon request.

X ____________________ Date of Signing ____________________
Signature of Patient

X ____________________ Time of Signing ____________________
Signature of Patient's Representative

X ____________________ Witness ____________________
Relationship of Patient's Representative

Witness ____________________

If patient is unable to sign, state reason: ____________________

IT IS UNDERSTOOD THAT THIS AGREEMENT SHALL TAKE EFFECT UPON REGISTRATION EVEN THOUGH IT MAY BE SIGNED PRIOR THERETO.

NOTE: A COPY OF THIS AGREEMENT IS TO BE DELIVERED TO THE PATIENT UPON REQUEST. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.