8550 Cuthills Circle, Lincoln NE 68526

☐ Behavioral Health
Phone: 402-476-6060
Fax: 402-476-6809

☐ Neurology
Phone: 402-476-6060
Fax: 402-476-6809

☐ Primary Care
Phone: 402-466-3355
Fax: 402-466-3410

Patient Name: ____ Date of Birth: _____________________________________

I hereby authorize Alivation Health, LLC: "Please Select One"

☐ To "Provide" Protected Health Information "To":
(patient agrees that Alivation can *share* your health information *with* the person below)

☐ To "Receive" Protected Health Information "From":
(patient agrees that Alivation can *receive* your health information *from* the person below)

☐ To "Receive" & "Provide" Protected Health Information "From":
(patient agrees that Alivation can *receive* your health information *from* the person below)

Name:____ Address:____
Phone:____ Fax:_______________________________________
Email:____ @ ______________________________________

Purpose of Request (*Must check one*):

☐ Request to communicate to Patient/Individual * note: that some items will not be released due to specialty
☐ Attorney/Legal ☐ Coordination of Care or Consultation
☐ Transferring Care ☐ Billing/Claims ☐ Other(specify)________________________

I Request My Records be Provided:
☐ Electronically via MyHealthRecord (Via Patient portal) ☐ Paper (fees may apply) ☐ Electronically via email* ☐ Electronically via CD*

Please check the type of information to be released *(check all that apply)*:
NOTE: *This form MAY NOT BE used to release Psychotherapy Notes*

☐ From (date): ________________________ To (date): ___________________________
**Includes all records through the date the patient or patient representative signs this authorization*

☐ Consultation(s)/ Encounter Notes ☐ PFT/Spirometry ☐ History/Physical Exams

☐ Physician(s) Orders ☐ Diagnostic Testing Reports ☐ Immunization Records

☐ Sleep Study Reports ☐ Lab Test Result(s) ☐ Questionnaires

☐ EKG/Cardiology/Report(s) ☐ Patient Medication(s) ☐ Radiology/Image(s)

☐ Pathology Report(s) ☐ Other (specify): ____

Release of Information Updated: 4.08.19aw

Drug and/or Alcohol Abuse, and/or Psychiatric, and Communicable/Non-Communicable Diseases:
I understand my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), or other sexually transmitted diseases (such as hepatitis, gonorrhea), psychiatric care, drug and alcohol abuse/treatment, or other sensitive information, I agree to its release. *Check One*: ☐ Yes ☐ No

EXPIRATION DATE: I understand that this authorization shall be in force and effect **until ___________________ (state the specific expiration date or the event triggering the expiration)** at which point the authorization will expire. If left blank, release will automatically set to expire one year from the date signed.

REVOCATION OF AUTHORIZATION: I understand that I may revoke this authorization at any time by sending written notification to Alivation Health, 8550 Cuthills Circle, Ste 100, Lincoln, NE 68526. I understand that a revocation is not effective to the extent that the providing organization has relied on the authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

AUTHORIZATION FOR MARKETING: I understand that the authorized use or disclosure will result in a direct or indirect payment to the providing organization from a third party. (This section is necessary only if the authorization is for marketing purposes and involves direct or indirect payment to the covered entity from a third party.)

CONDITIONING OF AUTHORIZATION: I understand that the providing organization will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on me providing an authorization for the requested use or disclosure. Unless my treatment is 1) related to the research, 2) my health care services are provided solely for creating protected health information for disclosure to a third party, or 3) if the authorization is sought for a health plan to determine eligibility or enrollment for underwriting purposes.

Signature of Patient or (Legal Guardian): ______________________________________ Date: ______________________

Print name if signing as Legal Guardian: ____

Witness Signature (Alivation Health Team Member):

Print Name: _____________________________________ Date: __________________

Verified by (*OFFICE USE ONLY*):

☐ Action Needed: Comment: ____

☐ No Action Needed: Comment: Please keep on file

Task Sent to: ☐ Team Member: _______________
☐ BH Medical Records
☐ PC Medical Records

Release of Information Updated: 4.08.19aw

alivation HEALTH

Patient Information

Your health is of utmost importance to us. To assist in your evaluation, please fill out this form as accurately as possible. All information will be treated confidentially.

Date: ____________________________

Last Name:_____________________________________First Name:_____________________________________MI: ___________

Date of Birth: _______-_______-__________ SSN: _______-________-_________ Sex: Male ________Female ________

Address:____City: ____________________________State:_________Zip: ___________

Home Phone: (_______)________________Mobile: (_______)_______________Work Phone: (_______)_________________

Note: By providing the above information, you allow us to contact you at these telephone numbers or addresses.

Email address:____

Note: You must provide an e-mail to utilize our patient portal.

Marital Status (circle one): Married Single Widowed Divorced Separated

Parent/Guardian Name (18 and younger): ____

Parent/Guardian Phone Number (18 and younger): ______________________________

Primary Care Provider: ____City/State: _____________________________

May we provide your Primary Care Provider and Referring Provider with your individual health information to assist in the coordination of your health care? (circle one) Yes No

Please list anyone you authorize to receive information regarding your care (PMI):

Name:____ Relationship to patient:___________________ Phone:_____________

Name:____ Relationship to patient:___________________ Phone:_____________

Emergency Contact

Name:____Relationship to Patient: ____

Address: ____City: ___________________State: _________ Zip: ___________

Home Phone: (_______)________________Mobile: (_______)_______________Work Phone: (_______)_________________

alivation HEALTH

Patient Information

Patient Demographic Information

Preferred Language: ________________________________

Race		**Ethnicity**	
________	Caucasian or white	________	Hispanic or Latino
________	Black or African American	________	Not Hispanic or Latino
________	Asian	________	Not reported or decline to answer
________	Native Hawaiian or other Pacific Islander		
________	American Indian or Alaska Native		
________	Other		
________	Not reported or decline to answer		

Person Financially Responsible

Same as patient check here: ____________

If someone other than patient:

Name:________________________________Relationship to Patient: ________________________________

Address: ____________________________________City: ______________State: ________ Zip: _________

SSN: _________-_______-___________DOB: _____________Employer:______________________________

Home Phone: (______)_____________Mobile: (______)____________Work Phone: (______)______________

Are you covered by an employer's health insurance plan or that of a family member? ____________________

Insurance Information

Primary Insurance Company:__________________________________Phone Number: (______)____________

Policy Holder's Name:____DOB: ____________________

Relationship to Patient: Policy Number: ____

Secondary Insurance Company:________________________________Phone Number: (______)____________

Policy Holder's Name:____DOB: ____________________

Relationship to Patient: Policy Number: ____

Is this visit due to an accident or workers compensation of any kind? (circle one) Yes No

Medicare Patients

Are you a Veteran?___________

Do you have a Federal Black Lung Card? _____________

alivation HEALTH

Patient Information

The team at Alivation Health, LLC strives to exceed expectations in treatment and services to make your experience with us as comfortable and stress-free as possible. To do so, we have implemented several policies that we would like you to be aware of.

PLEASE INITIAL EACH ITEM.

___ **PROVIDER:** To ensure you receive the best care, your provider may change during treatment. Reasons for this may include insurance changes, provider specialty, or provider availability.

___ **COPAYMENTS:** Copays are due at the time of service, if you are unable to pay at the time of service you will be asked to reschedule your visit.

___ **SELF-PAY PATIENTS**: If you do not have insurance, your balance is due at the time of your office visit. If you are unable to pay at time of service, you will be asked to reschedule.

___ **INSURANCE CARDS**: Insurance cards are required at every visit. If you have not provided our office with the correct insurance information, you will be responsible for any balance due.

___ **MONTHLY BILLING STATEMENTS**: Every month our office sends out a monthly billing statement to every patient. The balance due is the remainder owed after your insurance has paid.

___ **COLLECTIONS**: If your account balance is unpaid and overdue after three attempts, to contact you and you have not responded to any of our attempts to contact you, your account will be referred to a collection agency. Once your account is in collections, you will be dismissed from our practice, which includes refill requests and appointments.

___ **PAYMENT PLANS**: If you have negotiated a payment plan with us, you are responsible for making timely and consistent monthly payments. If you fail to make your scheduled due date, your account will be sent to collections for non-payment.

___ **LATE FOR APPOINTMENTS:** If you arrive more than 15 minutes late we may need to reschedule your appointment or we may ask that you wait until the next open spot in the schedule while we continue to see the patients who arrived on time.

____ **SCREENING LABS:** If a screening lab is done at a physical, some of the charges from the lab may be applied to your deductible depending on individual coverage differences. Please speak with the provider if you would like a limited lab draw instead of the recommended full screening lab.

___ Our staff will treat all patients with the upmost respect and professional attitude. In return, we expect our patients to be courteous in our office. If a patient is consistently uncooperative, refuses to follow treatment plans, or uses demanding and abusive language our staff have the right to dismiss a patient from our practice for non-compliance.

I have read and understand all above policies.

______________________________ ______________________________ ______________

Patient Name (printed) Patient/Guardian Signature

alivation HEALTH

Patient Information

Authorization for Medical Treatment, Statement of Responsibility, Acknowledgement of Review of Notice of Privacy Practices, Patient Rights & Responsibilities, and Magellan Member Rights & Responsibilities

Patient Name: ____ Patient Date of Birth: _________________

Authorization for Medical Treatment

I authorize the physician(s), psychologist(s), therapists(s), their assistants and/or designees in charge of my medical care to administer any treatment as may be necessary or advisable in my diagnosis and treatment at Alivation Health, L.L.C., ("Facility). This authorization includes, but is not limited to, routine diagnostic procedures, rehabilitation therapy, laboratory tests, and the use of prescription medication. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to results of examination and treatment received at this Facility. I acknowledge that my care is under the direction of my treating physician(s) and the Facility will follow the instructions of my physician(s) in the provision of said care.

Statement of Responsibility

I understand that I am financially responsible to the Facility(s) as the patient, parent, guardian, conservator or insured for all charges not covered by the above assignments. Charges may include medical insurance deductibles, co-insurance, or out-of-pocket expenses.

Notice of Privacy Practices

I have been given the opportunity to review the Facility's Notice of Privacy Practices for Protected Health Information. I understand that the Facility has the right to change the Notice of Privacy Practices at any time, and that I may obtain a current copy at the Facility's office during normal business hours.

Patient Rights & Responsibilities

I have been given the opportunity to review the Facility's Patient Rights & Responsibilities. I understand that the Facility has the right to change the Patient Rights & Responsibilities at any time, and that I may obtain a current copy at the Facility's office during normal business hours.

Magellan Member Rights & Responsibilities

I have been given the opportunity to review the Magellan Member Rights & Responsibilities and I understand that I may obtain a current copy at the Facility's office during normal business hours.

The undersigned certifies that he or she has read the foregoing, is the patient, patient's guardian, power of attorney, parent, or is duly authorized by or on behalf of the patient to execute the above and accept its terms.

Print Name: ____

Patient/Guardian Signature: ____Date: _________________

alivation HEALTH

Patient Information

Insurance Release of Information/Assignment of Benefits

I authorize Alivation Health, L.L.C. to release to my Medicare carrier or the Insurance carrier provided on Patient Information sheet, any medical information needed for authorization or payment of this or a related claim. I also authorize payments directly to this office for the health benefits. I understand that I am responsible for all pre-authorizations required by my insurance. Furthermore, I understand that I am financially responsible for all charges whether or not paid by my insurance company.

Financial Agreement

Pre-Authorization for Mental Health Services

Most insurance companies require pre-authorization for mental health services, prescription medications, and certain medical treatments. We strongly encourage you to contact your insurance to inquire about any pre-authorization requirements. You may also want to obtain information regarding your health benefits. Most often, health insurance benefits for mental health are different from the benefits for general healthcare. Please contact our billing office should you have any questions regarding the information from your insurance.

Payment of Services

Patients are required to pay all co-pays, co-insurance, and balances on account at the time of service. If a payment cannot be made, a statement will be mailed and payable within 10 days of receipt. If payment cannot be made when due, you must contact our patient accounts department. After 90 days, if no payment has been received, necessary collection proceedings will begin. It is important that you notify us of any changes of address promptly, as undeliverable statements are turned over to collection proceedings immediately.

Insurance

If you have insurance, Alivation Health will complete and mail an insurance claim on your behalf. However, you are responsible for all pre-authorization requirements, insurance claim follow up, and all charges not covered by your insurance. Please contact your insurance to inquire about the portion of charges they will pay, prior to receiving your first explanation of benefits. It is often the case that insurance benefits for mental health are different from primary care. If you do not receive an explanation of benefits from your insurance company within 30 days of your date of service, please follow up with your insurance on the delayed claim. After you have spoken with your insurance company; please call the billing department to inform us of the progress on the claim.

Alivation Health reserves the right to charge the patient the full amount of the visit if there is no response from the insurance company within 45 days. If you have any questions regarding your account or the filing of your insurance claims, please call us at 402-476-6060. We will be happy to assist you.

Appointment No-Show Fee

I have been advised that this office requires a 24-hour prior notice on all appointment cancellations. I have been advised that there will be a **no-show fee** for appointments that are canceled with less than 24-hours notice. This fee is not covered by any insurance plan. Fee varies based on appointment type missed and are updated from time to time, for a breakdown of these fees please contact the billing department at 402-476-6060.

I understand and agree to abide by the above Insurance Release of Information/Assignment of Benefits and the Financial Agreement.

Print Name: ____

Patient/Guarantor Signature: ______________________________ Date: ____________

Important Patient Information

We can better serve your health care needs, if you are familiar with the following policies and procedures:

Office Hours & Appointments
The office is open Monday through Friday from 7:30 a.m. to 6:00 p.m. Our telephone hours are 8:00 a.m. to 6:00 p.m. Our providers are always available for an emergency. Follow-up appointments should be made before leaving the office. Appointments may also be scheduled by calling 402.476.6060 for brain/behavioral health, or 402.466.3355 for primary care. Occasional delays may occur in your appointment time, due to the nature of our practice and our patient needs. Please understand that these delays are unavoidable.

Cancellations
If you are unable to keep your appointment, please call us at least 24-hours before your appointment time, and we will be happy to reschedule your visit. Another patient who can be seen during the open time will be grateful for your thoughtfulness. Alivation Health reserves the right to charge a No-Show Fee for appointments that are canceled with less than 24-hours notice.

Prescription Refill Requests
Medications will only be filled during an appointment with your provider. It is important that we closely monitor your medication. If you need a refill prior to your next scheduled appointment, we **require** that you schedule a sooner appointment prior to receiving a prescription refill. If a refill is provided, it will only cover the days until your regularly scheduled appointment.

For refills of medication that require a written prescription, please call our office at 402.476.6060 and select the option for your provider's nurse. For all other medications, please call your pharmacy to request a refill and we will respond to your pharmacy as soon as possible. Please note that most medications require insurance authorization and this process can take **3-4 days**. If you miss your appointment, no refills will be given.

Provider Telephone Calls
Please call our office to ask a question, report a medication side effect, or the worsening of a condition. We will make every effort to return your call as soon as possible. Most often, calls will be returned within 1 business day. All calls received after 3:30 p.m. will be returned the following business day. However, at any time, if a call is urgent, press 1 for the patient service specialist who will immediately notify the nursing staff of your urgent call. If you encounter a true, medical emergency, call 911.

If you have questions, please call us or visit our website.

402.476.6060 (Brain/Behavioral Health) | 402.466.3355 (Primary Care)

Alivation.com