alivation HEALTH Next Level You

Name_____

DOB: _____/ _____/_____ Date:_____/ _____/_____

Please have this form completed and ready to discuss with your provider prior to your appointment beginning.

Over the last 2 weeks, how often have you been bothered by any of the following problems? *PHQ-9*	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things:	0	1	2	3
Feeling down, depressed, or hopeless:	0	1	2	3
Trouble falling or staying asleep, or sleeping too much:	0	1	2	3
Feeling tired or having little energy:	0	1	2	3
Poor appetite or overeating:	0	1	2	3
Feeling bad about yourself, or that you are a failure or have let down your family:	0	1	2	3
Trouble concentrating on things like reading or television:	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite: being so fidgety or restless that you have been moving around a lot more than usual:	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself:	0	1	2	3

{Office Use Only} PHQ-2 Total: _____ PHQ-9 Total: _____

Over the last 2 weeks, how often have you been bothered the following problems? *GAD-7*	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble Relaxing	0	1	2	3
Being so restless that it's hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3

{Office Use Only} GAD-7 Total: _____

Please rate your problems with concentration, memory, and thinking skills during the past 7 days. *BC-CCI*	Not at all	Some	Quite a bit	Very Much
Forgetfulness/ Memory Problems:	0	1	2	3
Trouble figuring things out/ problem solving:	0	1	2	3
Trouble expressing my thoughts:	0	1	2	3
Trouble finding the right word:	0	1	2	3
Poor concentration:	0	1	2	3
Slow thinking speed:	0	1	2	3

Office Use Only: BC-CCI Total: _____

Considering All of the above symptoms it makes it difficult for me to:	Not at all	Several days	More than half the days	Nearly every day
Be productive at my most recent job, schooling and/or daily activities	0	1	2	3
Have good relationships with my family & peers	0	1	2	3
Enjoy social/recreational activities and hobbies:	0	1	2	3

{Office Use Only} IM Total: _____

Name (Print): _____

Signature: _____

DOB: _____/ _____/_____ Date:_____/ _____/_____

Please have this form completed and ready to discuss with your provider prior to your appointment beginning.

Check the box next to each question if it applies to you.

General

☐ Are you pregnant? If so, stop here and let your provider know, you do not have to complete the rest of this form.

Have you ever been diagnosed with or do you experience any of the following conditions or symptoms?

☐ Dizzy and/or lightheaded when you stand up?	☐ Hypotension? (very low blood pressure)
☐ Diabetes?	☐ Rapid Heart Rate (Tachycardia)?
☐ High cholesterol?	☐ Hyperhidrosis (Excessive Sweating)?
☐ CVA, Stroke or TIA?	☐ Edema (swelling)?
☐ Hypertension (high blood pressure)?	☐ Atherosclerosis or blood vessel disease?
☐ Skin ulcers, numbness and tingling?	

Family Health History

☐ Has anyone in your immediate family (blood relatives) been diagnosed with cardiovascular disease (CVD), or had a heart attack?
☐ Has anyone in your immediate family (blood relatives) passed away from sudden cardiac death?

NOTICE OF HIPAA AND PRIVACY PRACTICES: This office protects your privacy as well as optimize your quality of care through access to your healthcare data. as part of your privacy, we will never share your information with a third party for marketing purposes. However, HIPAA guidelines allow sharing of general information for statistical reasons, such as a government health department or official third party. Your information may be used within this office or practice or with other healthcare professionals for training and educational purposes pursuant to HIPAA guidelines

8550 Cuthills Circle | Lincoln, NE 68526
Phone: 402.476.6060 | Fax: 402.476.6809
alivation.com

Patient Questionnaire-

Patient Name: _____ DOB: ___/___/___ Date: _____

Were you referred here? If yes, by who? _____

What are your current symptoms or concerns? _____

_____

Please list ALL of your current medications and dosages that you are taking as well as any side effects that you are experiencing. _____

_____

Have you seen a psychiatrist, therapist, or counselor in the past? If so, who did you see and when did you see them?

_____

_____

Have you been hospitalized for psychiatric concerns or gone to treatment in the past? If so when and where did you go?

_____

_____

Please list any medications that you have taken in the past and their effects _____

_____

_____

Who is your primary care provider? (i.e. where you go for physical illness), and when was the last time you were seen by them? If none, would you be interested in seeing a primary care provider at Alivation?

_____

Females:

Are you pregnant? Y/N If yes, who is your provider? _____ Are you breastfeeding? Y/N

How many times have you been pregnant? _____ How many births? _____ Do you use a form of birth control?

_____

Please check if you have any of the following chronic health conditions:

☐ Asthma ☐ Seizures ☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol

☐ Thyroid Problems ☐ Cardiac Problems ☐ Chronic Pain ☐ Other: _____

Please list any surgeries: _____

Are you allergic to any medications, foods, or have any environmental allergies? If so, to what and what kind of reaction? _____

_____

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Is there anyone in your immediate family with a mental illness or substance abuse problem? If so, who and what? Please list any medications that you know they are taking. _____

Where were you born? _____ Where were you raised? _____
How long have you lived at your current address and who lives with you? _____

_____

Are you in school? If so, what grade? _____

What is your highest level of education that you have completed? _____

Do you work? If so, where and what do you do? _____

Do you have a religious or spiritual preference? If so, what is it? _____

What is your family of origin (i.e. who raised you, how many siblings, ect)? _____

_____

Are you currently married? If so, how long? Any previous marriages? _____

Do you have any children? If so, please list age and sex. _____

_____

Do you drink alcohol? If so, how often and how many do you drink? _____

Do you use drugs? If so, what drugs and how often do you use? _____

Do you use any tobacco products? If so, what kind and how much do you use in a day? _____

Do you drink caffeinated beverages (i.e. soda, coffee, tea, or energy drinks)? If so, what kind and how many of each do you drink in a day? _____

Has there been any physical, emotional, or sexual abuse in the past? Y/N _____

Do you have any legal offenses or charges? _____

Has CPS been involved? If so, what is the name of the case worker? _____

Is there any history of disability? _____

Are you your own legal guardian? If not, please list name of guardian. _____

What pharmacy do you use? Would you like to use Alivation Pharmacy?

_____

Any other information that you would like us to know: _____

_____

_____

Contacting Us

Behavioral Health: 402-476-6060
Primary Care: 402-435-3355
Pharmacy: 402-476-6060

Appointments

We see patients by appointment and offer same-day appointments for patients with acute needs. If you call our office outside of regular business hours with a medical concern, you will be prompted to leave a message for the on-call provider who will triage those calls. To schedule an appointment, please call our office at (402) 476-6060. Existing patients can also request an appointment online through the Patient Portal. We understand that occasionally situations arise, and you may not be able to keep your scheduled appointment. We ask that you extend us the courtesy of 24 hours' notice, so we may use the time reserved for you to help other patients in need. If you miss three appointments, we reserve the right to discharge you from our practice.

Payment & Insurance

For the benefit of our patients, Alivation Health is contracted with most insurance companies. Our contracts require us to collect co-pays and balances at the time of your visit. We accept cash, checks and credit cards (Visa, Discover, and MasterCard). Some services we offer, such as school physicals and weight management services, may not be covered by insurance. Insurance coverage varies based on each patient's individual insurance plan.

Prescriptions

Please check your medication supply prior to your visit so we can order refills at the time of your appointment. We process refill requests only during normal business hours and we require a 72-hour turnaround. You can follow up directly with your pharmacy after 48 hours. We will call you only if we have a question regarding the refill. Our practice does not manage chronic pain. If you have a chronic pain condition, we will refer you to a pain management specialist. For your convenience, Alivation Pharmacy is located onsite and provides bubble-packing and mail service.

Medical Records

Your medical records are strictly confidential. We are prohibited from releasing any information from your records without your express written permission. Please allow five to seven business days for us to complete any requested forms, prior authorizations, or letters. Be advised that some forms and letters may require an office visit or have a fee to complete them.

Alivation Brain Health Optimization Program

At Alivation Health, we promise cutting-edge treatments with personalized, dependable care from an expert team. We believe that to ensure the best possible outcomes, it is necessary to fully utilize our Brain Health Optimization program. Participating in our program provides patients access to full care with advanced technology and diagnostic assessments that are not available elsewhere.

Foundational to our program is our brain health assessment (EEG) and pharmacogenetic testing (DNA testing).

Electroencephalogram (EEG)

Our program utilizes an electroencephalogram (EEG) to detect and record electrical activity in the brain. It makes a significant, positive impact on patient care because it aids providers by measuring brain function and ongoing changes to meet each patient's specific needs. It unlocks information that can prove pivotal in determining the most effective treatment plan and a patient's ongoing care once reaching their desired outcome.

The results of the assessment equip providers with information that:

- Assists in diagnosis, helping determine the best treatment option sooner
- Helps in continuous monitoring of treatment
- Helps the provider evaluate alternative treatment options when other plans are not working
- Provides an objective and earlier alert of potential issues that when proactively addressed can prevent full-blown symptoms arising

We request that all new patients receive an initial "point of reference" EEG. If the patient has not previously been on psychotropic medications, they will complete a second EEG four weeks after starting new medication. Completing the second assessment allows the provider to evaluate the medication effectiveness by comparing the results to the initial EEG results. The provider can then adjust the medication or verify its effectiveness. If the patient is taking stimulant medication an EEG will be performed twice, one while on the stimulant, and one while off the stimulant.

Pharmacogenetic Testing (DNA Testing)

Genetic differences can influence a patient's ability to metabolize medications and can alter the effectiveness of a medication. Pharmacogenetics, (also called DNA Testing) is the study of how an individual's DNA affects their response to medication. Genetic testing equips providers with useful information to support their prescription medication decisions. The results show how a patient may potentially react to certain types of medication, including which side effects they are more likely to experience based on their genetic makeup. Thus, as part of our program, we request that each patient complete a pharmacogenetic test at their first visit.

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: (_____)_____

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Patient Information

Patient Demographic Information

Preferred Language: _____

Race

_____ Caucasian or white
_____ Black or African American
_____ Asian
_____ Native Hawaiian or other Pacific Islander
_____ American Indian or Alaska Native
_____ Other
_____ Not reported or decline to answer

Ethnicity

_____ Hispanic or Latino
_____ Not Hispanic or Latino
_____ 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. Please be aware of the following policies:

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.

___ 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.

___ 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	Date

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 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.

No Show Fees:

- Behavioral Health Medication Management and Primary Care - $50
- Therapy - $75

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.

No Show Policy

To provide you with the most effective treatment plan it is essential that you show up for all scheduled appointments. We understand that in certain situations, you must cancel your appointment. Please call to cancel at least 24 hours in advance.

If you do not show for your scheduled appointment, you will be charged a No-Show Fee. The fee must be paid prior to scheduling your next appointment. Patients who no show for their appointment four times will be dismissed from Alivation due to non-adherence to treatment compliance.

No Show Fees:

- Medication Management - $50
- Therapy - $75

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

Email Correspondence Consent Form

Below is information about maintaining your privacy and enhancing communication via email. Your decision to utilize email is strictly voluntary and your consent may be rescinded at any time.

When should I NOT use email to communicate with Alivation Health?

- In an emergency
- If you are experiencing any desire to harm yourself or others
- If you are experiencing a severe medication reaction
- If you need an immediate response

What are the risks of using email?

- Email may be seen by unintended viewers if addressed incorrectly
- Email may be intercepted by hackers and redistributed
- Someone posing as you could access your information
- Email can be used to spread computer viruses
- Emails are discoverable in litigation and may be used as evidence in court
- Emails can be circulated and stored by unintended recipient

What are my obligations?

- I must let Alivation Health know immediately if my email address changes
- I will advise Alivation Health in writing if I decide that I do not want to continue communicating via email
- To avoid possible confusion, I will not use internet slang or shorthand when communicating via email

What steps has Alivation Health taken to protect the privacy of my email communications?

- Has installed software for encrypting email messages
- Set up a password protected screensaver on computers
- Educated staff on the appropriate use and protection of email
- Does not access patient email from public Wi-Fi hotspots
- Will not transmit highly sensitive information via email
- Will not forward patient email to third parties without your express consent

CONSENT TO EMAIL USE

By signing below, I consent to the use of email communication between myself and Alivation Health for the purposes of information about my appointments, general operations, or marketing. I recognize that there are risks to its use, and despite Alivation Health's best efforts, they cannot absolutely guarantee confidentiality. I understand and accept those risks and the policies for email use outlined in the form. I also understand that I may withdraw my consent to communicate via email at any time by notifying Alivation Health in writing.

_____ _____

Patient/Legal Guardian Name Email Address

_____ _____

Patient/Legal Guardian Signature Date

alivation HEALTH
8550 Cuthills Circe | Lincoln, NE 68526
Phone: 402.476.6060 | Fax: 402.476.6809
alivation.com

Release of Information

☐ **Behavioral Health** ☐ **Primary Care** **Patient Name**_____ **DOB**_____

I hereby authorize Alivation Health, LLC (*must check at least one)*:

☐ To "Provide" Protection Information "To": (patient agrees that Alivation can *share* your health information *with*:)

☐ To "Receive" Protection Information "From" (patient agrees that Alivation can *receive* your from *from:*)

Name:_____ Phone:_____ Fax: :_____

Address:_____ Email:_____

Purpose of Request (*must check at least one)*:

☐ Communicate to individual above* note: some items will not be released due to specialty ☐ Attorney / Legal

☐ Coordination of Care/Consultation ☐ Transferring Care ☐ Billing ☐ Other _____

I Request my records be provided (*must check at least one)*:

☐ Electronically via MyHealthRecord ☐ Paper (fees may apply) ☐ Electronically via email ☐ Electronically via CD*

Please check the type of information to be released (*check all that apply):*

☐ All previous dates ☐ From (date) _____ To (date) _____

☐ Consultations/Encounters	☐ PFT / Spirometry	☐ History / Physicals	☐ Orders	☐ Diagnostic Testing Reports
☐ Immunization Records	☐ Lab Test Results	☐ Questionnaires	☐ Meds	☐ EKG/Cardiology/Reports
☐ Sleep Study Reports	☐ Radiology/Images	☐ Pathology Reports	☐ Other: _____	

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 on 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 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 overage 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 request 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: _____

Alivation Health Witness Signature: _____ Date: _____

Office Use Only

Action Needed (leave blank if none):_____