alivation HEALTH

Adult History

Patient Name: _____ Date: _____

Date of Birth _____ Age _____ Marital Status (circle one) S M D W

Occupation _____ Years of Education _____ Pref. Pharmacy _____

List all Medications you now take, INCLUDE prescribed, over- the-counter, vitamins, drops and topicals:

Medication Dose Times daily

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Allergies: (list medication and reaction) _____

_____

_____

_____

_____

Do you have an Advance Directive? Y N

If yes, has a copy been furnished? Y N Denied

Operations: (list any operations and dates performed) _____

_____

Other hospitalizations and illnesses: _____

_____

Other illnesses (chronic) _____

Health Review (Mark the ones that best describe you)

Tobacco:	None	Pipe/Cigar	Chew	Cigarettes	Amount daily	How Long?	Quit?
Alcohol:	1/week-2/day	Weekends	None	Over 2 drinks daily		Quit	
Coffee:	0-4 cups daily	More: _____					
Meals:	Regular low-fat	Regular	Often skip	Fast food			
Exercise:	Regular	Occasionally	Rarely	No			
Use of seat belts:		Yes	Occasionally	No			
Use of Street Drugs:		No	Yes Details: _____		Last tetanus shot date: _____		

Family History (Mark the ones that best describe your family)

	Age	Deceased	Alcoholism	Arthritis	Asthma	Bleeds Easily	Cancer	Diabetes	Epilepsy	Heart Disease	High Blood	High Cholester	Kidney Disease	Mental Illness	Migraine	Stroke	TB	Thyroid Disease	Other
Father																			
Mother																			
Bro/Sis																			
Bro/Sis																			
Spouse																			
Child																			
Child																			
Child																			

Please provide more details of Cancer, Mental Illness or other, including age of onset: _____

_____

_____

Patient Name:_____Date of birth: _____

Have you had the following symptoms or problems either in the past or now?
Please check the appropriate boxes.

General

Current	Past	
☐	☐	Anemia
☐	☐	Unexplained weight gain
☐	☐	Unexplained fatigue/weakness
☐	☐	Thyroid problems
☐	☐	Diabetes or high blood sugar
☐	☐	Fever or chills
☐	☐	Unusual lymph glands
☐	☐	Cancer
☐	☐	Rashes
☐	☐	Risk Factors for AIDS
☐	☐	Sleep difficulties
☐	☐	None of the above

Head

Current	Past	
☐	☐	Migraine
☐	☐	Frequent, severe or unusual headaches
☐	☐	Change in vision
☐	☐	Wear glasses/contacts
☐	☐	Glaucoma
☐	☐	Hearing difficulty
☐	☐	Nosebleeds
☐	☐	Sinus problems
☐	☐	Hair loss
☐	☐	Dentures/bridge
☐	☐	Bleeding gums
☐	☐	Persistent hoarseness
☐	☐	Difficulty swallowing
☐	☐	Hay fever
☐	☐	None of the above

Lungs

Current	Past	
☐	☐	Shortness of breath
☐	☐	Asthma or emphysema
☐	☐	Frequent cough
☐	☐	Coughing up blood or phlegm
☐	☐	Tuberculosis
☐	☐	Recurrent pneumonia or bronchitis
☐	☐	Wheezing
☐	☐	None of the above

Heart

Current	Past	
☐	☐	Heart murmur
☐	☐	Heart failure
☐	☐	Waking up at night due to shortness of breath
☐	☐	High blood pressure
☐	☐	Rheumatic fever
☐	☐	Chest pain, pressure, discomfort
☐	☐	Heart attack
☐	☐	Irregular heartbeat
☐	☐	Swelling in the legs
☐	☐	Calf pain
☐	☐	Racing Heart
☐	☐	Blood transfusion
☐	☐	Easy bruising or bleeding
☐	☐	None of the above

Gastrointestinal

Current	Past	
☐	☐	Indigestion or heartburn
☐	☐	Ulcer
☐	☐	Unexplained abdominal pain
☐	☐	Vomiting or bleeding
☐	☐	Hepatitis or liver problems
☐	☐	Frequent diarrhea
☐	☐	Constipation
☐	☐	Hemorrhoids
☐	☐	Rectal bleeding
☐	☐	Black tarry bowel movements
☐	☐	Change in bowel movements
☐	☐	None of the above

Urinary

Current	Past	
☐	☐	Bladder or kidney infection
☐	☐	Kidney stones
☐	☐	Burning with urination
☐	☐	Slow urine flow
☐	☐	Difficulty starting or controlling urine stream
☐	☐	Blood in urine
☐	☐	Venereal disease
☐	☐	Sexual problems
☐	☐	None of the above

Men Only

Current	Past	
☐	☐	Prostate problems
☐	☐	Discharge from penis
☐	☐	Lump in testicles
☐	☐	Erectile dysfunction
☐	☐	None of the above

Women Only

Current	Past	
☐	☐	Breast lump
☐	☐	Discharge from nipple
☐	☐	Irregular periods
☐	☐	Abnormal vaginal bleeding or spotting
☐	☐	Abnormal PAP test

Last Pap Date:_____
Age at onset of periods_____
Cycle:_____Days
(from start to start)
Birth control method _____
Number of pregnancies_____
Number of children _____
Number of living children _____
Number of adopted children _____
None of the above _____

Bones/Joints/Muscles

Current	Past	
☐	☐	Painful or swollen joints
☐	☐	Persistent back or neck pain
☐	☐	Muscle cramps
☐	☐	Osteoporosis
☐	☐	None of the above

Psychological

Current	Past	
☐	☐	Suicidal thoughts
☐	☐	Suicide attempt
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Crying spells
☐	☐	Memory problems
☐	☐	Sleep problems
☐	☐	Job or family difficulty
☐	☐	Loss of interest in previously enjoyable activities
☐	☐	None of the above

Neurological

Current	Past	
☐	☐	Seizure or epilepsy
☐	☐	Stroke
☐	☐	Numbness of face, arm or leg
☐	☐	Weakness of face, arm or leg
☐	☐	Difficulty with speech
☐	☐	Fainting or loss of consciousness
☐	☐	None of the above

Other

Current	Past	
☐	☐	Have you seen a specialist?

Name of specialists'
_____
_____
_____

Do you currently use a glucometer or other medical equipment? _____
Brand of glucometer _____
Other medical equipment _____
_____

Do you feel well? _____

Do you have anything else to add to your medical history?
_____
_____
_____
_____
_____
_____
_____
_____

Please complete both sides

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?	☐ Do you have an implanted pain pump or implanted insulin pump?
☐ Do you have a pacemaker or defibrillator?	☐ Do you have any electrical or metal implants or sensors of any kind?

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

☐ Do you have high cholesterol?	☐ Do you often feel fatigued?
☐ Do you have hypertension (high blood pressure?)	☐ Do your hands and feet get cold easily?
☐ Do you have diabetes?	☐ Have you ever experienced vision loss?
☐ Do you experience abdominal pain?	☐ Do you experience disturbance in your speech
☐ Peripheral Vascular Disease (PVD - Circulation disorders in blood vessels)?	☐ Buerger's Disease (Inflammation or clotting in blood vessels in hands or feet)?
☐ Atherosclerosis of the Aorta?	☐ Do you have or have you had Gangrene?
☐ Arteriovenous Fistula?	☐ Transient Cerebral Ischemia (TIA, mini-stroke)?
☐ Diabetes Type I with circulatory disorders?	☐ Diabetes Type II with circulatory disorders?
☐ Raynaud's Syndrome (discoloration of the fingers and/or toes when exposed to changes in temperature (cold or hot) or emotional event)?	☐ Do you have Chronic Skin Ulcer(s)? Stage II, III, or IV?
☐ Cerebrovascular Disease (CVA, Stroke)?	☐ Embolism of the upper limb/limbs (Artery obstruction in the arms)
☐ Diabetes Type I with neurological symptoms?	☐ Diabetes Type II with neurological symptoms?
☐ Do you ever have pain in your arms and/or legs?	☐ Do you ever notice a disturbance in the sensation of your skin (Tingling or numbness)?
☐ Edema (Swelling in arms and/or legs)?	☐ Peripheral Neuropathy (a result of damage to your peripheral nerves, often causes weakness, numbness, or pain usually in the hands and feet. It can also affect other parts of the body)
☐ Dizzy and/or lightheaded when you stand up?	☐ Degenerative Disease (as arteriosclerosis, diabetes mellitus or osteoarthritis) characterized by progressive degenerative changes in the tissue?)
☐ Reflex Dystrophy (Chronic Pain in Limbs after injury, stroke or Heart attack?)	☐ Idiopathic Peripheral Neuropathy? What the cause can't be determined, it's called idiopathic neuropathy. Includes numbness, tingling and pain in legs and or feet.

Regarding your personal and Family Health History

☐ Do you smoke or have you ever smoked?	☐ 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?	☐ Do you have a history of CVA or Tia (stroke or mini-stroke)?

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

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.

8550 Cuthills Circle | Lincoln, NE 68526
Phone: 402.466.3355 | Fax: 402.466-3410
alivation.com/primary-care/

Alivation Primary Care New Patient Information sheet

Medication Information

Medication Lists

- Please bring all medications with you to all appointments. This allows our providers to not only review the medications that our office is prescribing, but also to review medications taken over the counter on a regular basis and medications prescribed by other providers. Also please notify your provider if there have been any medication changes since your last visit. Note- these medications may not be reviewed at each visit but are there if the provider needs them.

Controlled Substances

- Any medication that is considered a controlled substance will require an appointment for refills.
- These patients will need to be seen every 4 weeks if they are only doing medication therapy.
    - If you are compliant with our EEG Protocols, you may be seen up to every 8 weeks.
- These appointments are necessary to check appropriate lab levels, brain health monitoring, monitor usage and effects closely, as well as provide Next Level Care.
- Example of Controlled Substances:
    - Sleep Aids, Anxiety Relief, Pain Relief, ADHD Medication
- Note: Alivation has a policy against prescribing chronic narcotic medications for chronic pain.

Appointment Information

Office Visit & Follow Up Norms

- Due to healthcare regulations and time constraints, providers will be addressing one, and at most two concerns each visit.
- Please prioritize your concerns to the top 1-2 concerns each visit.
- You certainly may schedule another visit regarding any further concerns for a future date.

Scheduling Follow-Ups after a Lab, Test or Procedure

- Please schedule a follow up appointment each time a test is performed, or a lab test is ordered.
    - Results are usually received in our office 7-10 days after the test is completed.
- We are not able to provide you with the results of labs, x-rays, MRI etc. over the phone.
- Please schedule your next appointment to review the results prior to leaving the clinic.

Physicals, Well Child Checks, Pre-Ops, and other Preventative/Screening Visits

- Providers are unable to discuss new problems at Preventative and Screening Visits
    - You may be asked to:
        - Address new issues at a different visit.
        - Reschedule (at no cost) your current visit, if your other need is urgent.
            - We would then see you for that issue during your scheduled visit time.
- Due to insurance regulations, we are only able to see you for one type of visit per business day.

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

_____ 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):_____