FILLMORE COUNTY HOSPITAL

Fillmore County Hospital is committed to providing high quality, personalized healthcare with compassion, dignity, and respect in a cost effective and safe manner - to achieve this we want you to have the opportunity to focus more on receiving treatment for your condition.

As paperwork is also important to your care, we feel that by spending time completing papers prior to your visit will provide accuracy. You can complete them at your own pace in a more private setting by doing these in your own home. This will also save you time when you present to the admission desk at the time of your visit.

Enclosed is information required to be completed prior to your visit with us. Some information is for Fillmore County Hospital and others may be for the specialty physician you are scheduled to see.

Please use the check list below as a 'reminder for your upcoming visit. If you have any questions, please call us at 402-759-4924 or 1-800-277-0706.

If instructions are included for your procedure, please read and follow them accordingly. If you have any questions, please do not hesitate to call. These are yours to keep.

To avoid duplicate work on your part, please fill out the forms in their entirety and bring them to your scheduled visit.

Patient Information Data _Medicare Questionnaire _Specialty Physician Questionnaire

☐ Bring insurance card(s). It is your responsibility to contact your insurance company for pre-certification or pre-authorization prior to having procedures/tests that request them. If your pre-certification or pre authorization is not done prior to your procedure re/test, your insurance company will penalize you and will not pay their portion of the bill. You will then be responsible for payment.

If you are under the age of 19, a parent/guardian must be present to sign the consent the day of visit or your Parent/ guardian may make arrangements to have the consent signed prior to the visit by contacting the Admission Office.

If no information is given in the scheduled appointment box to the right, someone from Fillmore County Hospital or your specialty physician office will be contacting you.

Sincerely,

The Specialty Clinic Team
Fillmore County Hospital

_____
Name
Your scheduled appointment is:
_____
Day Date Time
_____
Scheduled Physician or Procedure
We will contact you if this changes.

FILLMORE COUNTY HOSPITAL
(402) 759-3167. 1900 F STREET. GENEVA. NE 68361. *www.myfch.org*

MID NEBRASKA FOOT CLINIC

A STEP IN THE RIGHT DIRECTION

Patient Registration Form

Patient Information

Last Name:	First Name:	MI:	Social Security #

Date of Birth:	Sex: Female Male	Marital Status: D M S W

Street Address:	City:	State:	Zip:

Home #:	Cell #:	Work#:

Preferred Method of Contact for Appointment Reminder Calls: Voice Email
(MNFC is not liable for any wireless charges you may incur by choosing to receive email messages.)

Email Address:

Family Physician:

DATE LAST SEEN:

Preferred Pharmacy Name and Location:

Emergency Contact Name & Phone #:

Employer Name & Phone #:

Additional Information and Responsible Party

Additional Information and Responsible Party

Person Responsible for the ill (ONLY IF DIFFERENT FROM PATIENT):

Date of Birth:	Social Security #:	Phone #:

Street Address:	City:	State:	Zip:

Is your visit today due to one of the following (please circle):
ACCIDENT AUTOMOBLIE ACCIDENT JOB RELATED ACCIDENT

DATE OF ACCIDENT:

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW)

Race (please circle one):	Ethnicity (please circle)	Preferred Language:
White	Hispanic or Latino	English
Hispanic	Not Hispanic or Latino	Spanish
Other	Decline	Other:
Asian		
American Indian or Alaska Native		
Black or African American		
Decline		

How did you hear about Mid Nebraska Foot Clinic?

Insurance Information

Ins. Co. Name	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Secondary Insurance:

The above information is true to the best of my knowledge. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to MNFC all money to which I am entitled for medical expenses related to the services performed from time to time by MNFC, but not to exceed my indebtedness to MNFC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency.
MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to MNFC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient / Guardian Signature

/ /
Date

AGREEMENT/CONDITIONS OF TREATMENT

THIS IS AN AGREEMENT BETWEEN DR. LEWANDOWSKI **, AND MYSELF,** SUMMARIZING OUR DISCUSSION AND UNDERSTANDING OF THE CONDITIONS UNDER WHICH WE MUTUALLY CONSENT TO TREAT MY FOOT/ANKLE PROBLEMS.

1. **I UNDERSTAND** that my physician, Dr. LEWANDOWSKI, will use his/her best skill and judgment to accomplish the desired result, but that Dr. LEWANDOWSKI, cannot and does not warrant or guarantee such result; also that his/her forecast of the length of time involved in therapy and/or recovery from surgery, the manner of recovery and the possible complications or untoward results is based upon the usual and average response in cases similar to mine, but that is not a promise, since my result/response may be different from the usual.

2. On my part, **I PROMISE FULL COOPERATION WITH DR.** LEWANDOWSKI **AND HIS STAFF IN MY TREATMENT,** whether by surgical or nonsurgical means. I understand that if I do not follow my doctor's instructions or the instructions of his/her staff concerning my care and treatment, including any necessary physical therapy, the outcome of my care and treatment could be put into jeopardy and a bad result may occur.

Patients or authorized person's signature: I authorize the release of any medical or other information necessary to process any medicare claims. This also includes all other insurance coverages.

PATIENT'S SIGNATURE:_____ DATE:_____

Mid Nebraska Foot Clinic
820 W. Division Grand Island, NE 68801
Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can will be used to:

*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.

* Obtain payment from third-party payers.

* Conduct normal healthcare operations such as quality assessments and physician certifications.

*Specify uses and disclosures of protected health information (PHI)that require written patient authorization, such as marketing and fundraising.

*Include a statement of the right of the patient to be notified of an unauthorized disclosure of PHI.

*Inform patients that the practitioner must withhold information from an insurance company if the patient so requests and pays out of pocket in full for services.

I have received, read and understand your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this organization at any time at the above address to obtain a current copy of the notice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patients Name:_____

Relationship to Patient:_____

Signature:_____

Date:_____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, but was unable to do so as documented below:

DATE:_____INITIALS_____REASON_____

NOTICE TO ALL PATIENTS

Any item or service the doctor needs to use to treat your condition properly if deemed not medically necessary or not covered by your benefit plan maybe something our office will need to balance bill for. Our office is happy to assist in any way we can by sending in and processing all claims we feel have a chance of being paid by your insurance. There will be no returns allowed on any piece of durable medical equipment as reuse is prohibited by law. We sincerely thank you for your patronage and look forward to serving you.

*Some items such as ice wraps, shower protectors, lotions, and other over the counter pharmaceuticals are not sent to insurance as they are simply not covered and will have to be paid by the patient.

Mid Nebraska Foot Clinic
James E. Lewandowski, DPM

Medicare requires this to be completed by all Medicare members

Medicare Secondary Payer Questionnaire (To Be Completed By All Medicare Patients)

Name:_____Date of Service_____

(If any answer to question 1a through 4 is yes, the corresponding section of the "Other Insurance" form must be filled out completely.)

	YES	NO
1. Is the patient a Veteran?		
a. Did the VA refer you here for treatment?	_____	_____
b. Does the patient have a VA "Fee Basis ID Card?	_____	_____
	_____	_____
2. Do you have a Federal Black Lung card?	_____	_____
3. Is this medical condition due to and accident of any kind?	_____	_____
If yes was it: Work related___ Auto ___Injured in own home ___Other___		
4. Is the patient covered by an employer's health insurance plan throught their own employment or that of a family member?(Not retiree coverage)	_____	_____