PERMISSION FOR VERBAL COMMUNICATIONS

(To be used only by patients 19 years of age and older)

_____ _____
(Print name of patient) (Birth date of patient)

_____ _____
(Street address of patient) (City, state, zip code)

_____
(Phone number of patient)

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I permit Lincoln Pediatric Group, their physicians, nurses and other personnel ("Health Care Providers") to discuss my medical care and information, in person or by telephone, with the persons listed below (please write "none" if you don't want provide this permission to others):

	Name	**Phone Number**	**Relationship**
1.	_____	_____	_____
2.	_____	_____	_____

- All of the information about my care and/or listed in my medical record may be discussed with the person(s) listed above EXCEPT the following: _____
- Release of information under this document is limited to verbal discussions with my Health Care Providers. <u>This document does not authorize release of paper or electronic medical records</u>.
- This authorization expires on the following date: _____. If no date is indicated, this form will remain in effect until revoked.

Patient's Signature: _____ Date: _____
(Patient must sign if 19 years of age or older)

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Sign and return to: Lincoln Pediatric Group
4501 S 70th St. #110
Lincoln, NE 68516
Phone: (402) 489-3834
Fax: (402) 489-5049

<u>PLEASE COMPLETE THE OTHER SIDE OF THIS FORM</u>

LINCOLN PEDIATRIC GROUP, LLC
FINANCIAL POLICY
(To be used only by patients 19 years of age and older)

_____ _____
Patient name (print) Date

In the event that your parent/guardian stops assuming financial responsibility for your account, you understand and agree to the following:

If you do not have insurance, payment is due at the time services are rendered unless alternate payment arrangements are made with our billing staff. To assist you, we accept cash, checks, MasterCard or Visa.

If you have insurance, we will file your primary and secondary insurance for you as a courtesy if you have provided us with your current insurance information, and if you have authorized your insurance company to pay us directly. **You must realize, however, that your insurance is a contract between you and your insurance company. Payment to us is your responsibility**. If, at the end of ninety days, your insurance company hasn't remitted payment to us, payment will be due in full from you. If your insurance company requires co-payments or deductibles as a part of your plan, these payments are collected upon check-in. If a service is not a covered benefit in your insurance plan, you are responsible for the payment to us.

We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account. A finance charge of 1% per month is added to all overdue accounts. There is a service charge of $15.00 for each returned check. We do use outside agencies as a means of collection should we deem it necessary.

The person signing this financial policy is responsible for any and all payments for services. Any legal agreement, or other disagreement, between two parties as it relates to payment for our services must be dealt with between those parties and does not involve Lincoln Pediatric Group, LLC.

If you have any questions about the above information, please call (402) 489-3834 and ask for someone in the billing department. We are here to help you.

AUTHORIZATION: I have read and agree to the terms and conditions listed above. I hereby authorize the release of any medical information necessary to process my health insurance claim(s) and authorize payment of benefits directly to Lincoln Pediatric Group, LLC. I understand I am financially responsible to Lincoln Pediatric Group, LLC for charges not covered or denied by my insurance company. I further agree to pay the cost of collection, court costs, and other reasonable fees should they be required in the event of my nonpayment. I understand and agree that any cellular or land line phone numbers and email addresses provided to this office and to any of our service providers, now and in the future, may be used as a means to contact me, and this office and our service providers may leave messages for me manually and by using automatic systems such as by artificial or prerecorded voice or text and disclose the nature of the communication.

_____
Signature of patient

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM