Date __________ Norfolk Medical Group at Fountain Point 402-844-8000

MCARE / MCARE Advantage Plan

PATIENT INFORMATION

Name-Last__________________________First_____________________Middle______________________

Mailing Address________________________________City_____________________ St_______Zip________

Street Address_________________________________ City____________________ St_______ Zip________

Home Phone (_____)__________ Cell phone (_____)___________ e-mail ____________________________

Birthdate _______________ Sex ____ Marital Status (*circle one*) Married / Single / Widowed / Divorced / Separated

Race __________ Ethnicity (circle one) Non-Hispanic / Hispanic / Other Preferred Language ____________

SocSec# ______________ Employment/student status (circle one) Employed / Full-time student / Part-time student / None

EMPLOYER ____________________________________ EMPLOYER phone (_____)________

Address ___________________________________ City___________________St____ Zip_____________

PREFERRED METHOD OF CONTACT (please check only one box)

□ Home phone □ Cell phone □ E-mail □ Mailing address

I authorize NMG to leave voice message on my home or cell phone: □Yes □No

Spouse of Patient – I authorize discussion of my NMG billing with my spouse. Yes__ No ___

Name-Last_______________________ First____________________ Middle_____________ Birthdate _________

Mailing Address________________________________City_____________________ St_______Zip________

Street Address_________________________________ City____________________ St_______ Zip________

Home Phone (_____)_____________ Cell (_____)____________ Soc Sec# ______________ Sex ___

EMPLOYER ____________________________________ EMPLOYER phone (_____)________

Address ___________________________________ City___________________St____ Zip_____________

FINANCIAL POWER of ATTORNEY (present copy to receptionist for your chart)

Name-Last__________________________First_____________________Middle______________________

Street Address_________________________________ City____________________ St_______ Zip________

Home Phone (_____)_____________ Cell (_____)____________

EMERGENCY CONTACT #1 list a person not living with you.

Name-Last________________________________ First_____________________ Relationship ______________

Home Phone (_____)____________Cell phone (_____)____________Work phone (______)__________x__

EMERGENCY CONTACT #2 (if no spouse listed above)

Name-Last________________________________ First_____________________ Relationship ______________

Home Phone (_____)____________Cell phone (_____)____________Work phone (______)__________x__

Present Insurance Cards to the Receptionist

Primary ins company ____________________________ **Secondary ins company** _____________________________

Subscriber ___________________ **Birthdate** ________ **Subscriber** _____________________ **Birthdate** ________

1. I agree to be responsible for all charges incurred at NMG LLC including bad check charges.

2. I request that payment of authorized Medicare benefits be made on my behalf to any of the physicians represented by NMG LLC for any services furnished me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

3. I hereby authorize NMG LLC to furnish to the insurance company all information which they may request concerning my illness or injury. Information may also be disclosed to the referring physician/other health care providers, facilities, agencies. I hereby assign to NMG LLC the amount of money to which I am entitled for medical/surgical expenses for each claim. Insurance information not provided in a timely manner may result in patient responsibility for incurred charges because they may be past the TIMELY FILING DEADLINE.

4. I authorize discussion of my NMG bills with the following adult (other than spouse/POA listed above)

Name________________________________ Birthdate_____________ Relationship ______________

Name________________________________ Birthdate_____________ Relationship ______________

Signature________________________________ **Printed Name** _________________________ **Date**___________