Family Physicians Group, P.C.

770 N Cotner Blvd, Ste 205
Lincoln, NE 68505
(402) 467-4661

Peter Morin, M.D.
Nancy Baugous, M.D.
Thomas Fischer, M.D.

Welcome to Family Physicians Group, P.C.

The physicians and staff want to welcome you to Family Physicians Group. Our regular office hours are 8:00 am to 5:00 pm, Monday through Friday. If you need to contact a physician after hours for an emergency dial the office number, (402) 467-4661, and wait to be connected with an operator who will get in touch with the physician.

We do ask for payment at the time of service. If your coverage requires a copay we ask that it be paid at the time of your appointment. If your insurance coverage if through Midlands Choice, Blue Cross/Blue Shield, United Healthcare, Medicare or Medicaid we will file the claim for you.

We want to thank you for choosing our physicians to provide medical care for you and your family. If you have any questions or comments regarding your care at Family Physicians Group, please let us know.

Please sign and return to a receptionist. Signature of this letter will be kept on file to be used for filing insurance claims for certain health plans. Your signature is also an agreement to pay for the services provided by Family Physicians Group, P.C. You are financially responsible for any amount not paid for by your insurance company.

_____ _____

Patient/Parent/Legal Guardian Signature Date

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Patient's Date of Birth

Family Physicians Group

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At **Family Physicians Group** **(hereinafter referred to as "the Practice")**, privacy is one of our highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name and address and claims information. We use this information to provide service to you, to process your claims and to bring you health information that might be of interest to you.

Keeping information accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call or write us at the telephone numbers or addresses listed below. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How - and why - information is shared

We limit who receives information and what type of information is shared.

- *Sharing information within the Practice.* We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.

- *Sharing information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies and companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.

- *Other.* Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.

The Practice does not share any customer information with third-party marketers who offer their products and services to our patients.

Count on our commitment to your privacy

You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us – whether it's at our office, over the phone or through the Internet.

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Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Family Physicians Group creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I have been provided with a **Notice of Privacy Practices** that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to restrictions as to how my health information may be used or disclosed to carry our treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services and auditing functions, ect.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, weather written or oral or in electrical format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as the otherwise provided by law.
2. A photocopy or fax of this consent is a valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or healthcare operations be restricted. I also understand that the practice and I must: agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information which have been previously agreed upon.

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Patient's Name Printed Date of Birth

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Patient's Signature (or Guardian, if a minor) Date

PLEASE RETURN THIS PAGE ONLY TO FAMILY PHYSICIANS GROUP

Family Physicians Group

Authorization Regarding Communication Methods

A wide variety of means for communication exists and continues to broaden and develop. By signing this authorization, you agree that this office, and any third party used for treatment, billing, collection and other services, may use any means of communication with you. Thus, you understand and agree that any phone numbers and email address provided by you to our office and to any of our service providers, now and in the future, may be used as a means to contact you, and that we and our service providers may leave messages for you manually and by using automated systems such as by artificial or prerecorded voice.

Specifically, if you provide a cellular phone number or place a cellular phone call to us or any of our service providers, you consent and agree to accept collection calls and other communications to your cellular phone from us and any of our service providers. For any landline and cellular phone calls we or any of our service providers place to you, you consent and agree that those calls may be automatically dialed and that we and our service providers may contact you by sending text messages and emails to any phone number or email address you provide to us and to our service providers, and you consent to receiving such text messages and emails which may identify the name of our office or our service provider sending the communication, and which may disclose the nature of the communication.

Our office does not require you to sign this authorization as a condition of receiving treatment or purchasing any service. I certify that I have read and understand the above information.

_____ _____

Patient's Name Printed Date of Birth

_____ _____

Patient's Signature (Or Guardian, if a minor) Date