Nebraska
Surgical Specialists
Paul Kampfe, M.D.

2222 South 16th St., Suite 200
Lincoln, NE 68502
Ph. 402-475-9090
Fax 402-475-9092

Date:

REFERRAL INFORMATION

How did you hear about us? ☐ Google ☐ Yellow Pages ☐ Other:____________________

Who is your family or primary physician?

Are you seeing any other physicians? YES / NO If YES, Name(s): ____________________

PATIENT INFORMATION

Name:____________________Soc. Sec. #______-______-______
(FIRST) (MIDDLE) (LAST)

Email:____________________Home Phone: (______)____________

Address:____________________Cell phone: (______)____________

City:____________State:____________ZIP:____________

Birth Date:__________Age:______ Sex: ☐ M ☐ F Preferred Contact: ☐ Home ☐ Work ☐Cell Leave Voicemail? ☐ Yes ☐

Employed By: ____________________ Work Phone: (______)____________

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Partnered

Ethnicity: ☐ Non-Hispanic ☐Hispanic Preferred Language:____________ Race:____________

Emergency Contact Name:____________ Relationship:__________ Phone: (______)____________

INSURANCE SUBSCRIBER INFORMATION

Insurance Carrier: ____________ Policy #____________ Grp#____________

SUBSCRIBER info: Name:____________________

Birth Date:__________Soc.Sec.#______-______-______ Phone: (______)____________

Address (if different than patient):____________________

City:____________State:____________ZIP:____________

Employed By: ____________________Work Phone:(______)____________

WORKER'S COMPENSATION

Work Comp Address: ____________________

Work Comp Contact Name & Phone #: ____________________ Fax # ____________

Claim #:____________

Is treatment sought due to an accident or injury? ☐ Yes ☐ No

Is the accident/injury work related? ☐ Yes ☐ No

Is this accident/injury covered by Worker's compensation? ☐ Yes ☐ No

If you answered yes to any of the questions above, please fill out the following:

Date of Injury:____________________Time of injury:____________ ☐ AM ☐ PM

Where did injury happen? ____________________

How did injury happen?____________________

____

FINANCIAL POLICY

All charges for services rendered by Nebraska Surgical Specialists, LLC are due and payable in full at the time services are rendered.

For patients who have insurance: Your co-payment and assignment of benefits are required when services are rendered. Our office will submit insurance claims for you as a courtesy. You are responsible for charges that your insurance does not pay.

For patients who are uninsured: You are considered to be "self pay." You will be expected to pay for office visits on the date of service. If you are in need of surgery or a procedure, you will be expected to pay prior to the date of service.

No change to this agreement shall be effective unless in writing.

____ ____________________
Signature of Patient/Guardian & Relationship Date

ASSIGNMENT AND RELEASE:

I, the undersigned, have insurance coverage as listed in this document and assign directly to Nebraska Surgical Specialists all medical benefits, any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of any information necessary to process claims and or secure payment of benefits.

____ ____________________
Signature of Patient/Guardian & Relationship Date

ACKNOWLEDGEMENT OF NOTICE

I acknowledge Nebraska Surgical Specialists, LLC Notice of Privacy Practices. This notice describes how my health information may be used o disclosed. I understand that Nebraska Surgical Specialists, LLC reserves the right to change the Notice of Privacy Practice at any time.

____ ____________________
Signature of Patient/Guardian & Relationship Date

____ ____________________
Signature of Nebraska Surgical SpecialistsRepresentative Date

GOOD FAITH EFFORT:

- ☐ Presented the Notice of Privacy Practice to the patient/guardian, but the patient/guardian declined to acknowledge receipt.
- ☐ The Notice of Privacy Practice was mailed to the patient/guardian and the acknowledgement was not returned.
- ☐ Unable to sign because of medical condition.
- ☐ There was not a patient representative available to sign.
- ☐ Declined, stating he/she has already signed an acknowledgment.
- ☐ Other:____

____ ____________________
Signature of Nebraska Surgical Specialists Representative Date

CONSENT FOR RELEASE OF INFORMATION

Complete this section if you want to give consent for us to release information to:

1.)____/__________________________
Name Relationship

2.)____/__________________________
Name Relationship

3.)____/__________________________
Name Relationship

____/__________________________