Capital Medical Clinic

4701 Normal Blvd Lincoln, Nebraska 68506

402-488-5050 Fax 402-488-5001

Patient Information Form

Name_____ Date of Birth_____
Last First Middle Initial

Address_____
City State Zip Code

Male Female Single Married Widowed SSN_____
Circle one Circle one

Home#_____ Cell#_____ Work#_____

Employer_____
City State Zip Code

Emergency Contact_____
Relationship Phone#

Additional Contact (does not live in same household)_____
Name Phone#

Person Financially Responsible/Guarantor_____

Address_____
If different from above City State Zip Code

Phone#_____ SSN_____ Date of Birth_____

Subscriber (person your insurance is under)_____

Address_____
If different from above City State Zip Code

Phone#_____ SSN_____ Date of Birth_____

Primary Insurance_____ Secondary Insurance_____

ID#_____**Group#**_____ ID#_____Group#_____

Subscriber's Employer_____ Subscriber's Employer_____

Caseworker (if Medicaid)_____
Phone#

MEDICARE REQUIRES US TO HAVE A "ONE-TIME CONSENT AGREEMENT" ON FILE. YOUR SIGNATURE ON THIS FORM AUTHORIZES CAPITAL MEDICAL CLINIC, LLC, TO FILE YOUR CLAIM WITH MEDICARE AND/OR YOUR INSURANCE COMPANY. THEY WILL PAY OUR OFFICE DIRECTLY. THIS AUTHORIZATION WILL REMAIN IN EFFECT INDEFINITELY.

MEDICARE/PRIMARY INSURANCE LIFETIME ASSIGNMENT OF BENEFITS:
I HEREBY REQUEST AND AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO CAPITAL MEDICAL CLINIC, LLP, FOR SERVICES PROVIDED. I FURTHER AUTHORZIE THE RELEASE OF ANY MEDICAL INFORMATION TO ANY CARRIER LISTED ON THE CLAM FOR PURPOSES OF PROCESSING THIS, ANY RELATED MEDICARE, OR ANY INSURANCE CLAIMS. I ACCEPT RESPONSIBILTY FOR ALL SERVICES NOT PAID FOR BY MEDICARE OR MY INSURANCE COMPANY, SERVICES SHOWN ON YOUR BILLING STATEMENT, SERVICES SHOWN ON YOUR BILLING MAY BE DENIED BY MEDICARE PART B "NON-PROFESSIONAL ADMINISTRATIVE PERSONNEL" AS MEDICALLY UNNECESSARY EVEN THOUGH, BASED ON CURRENTLY ACCEPTED STANDARDS OF CARE, THE DOCTORS FEEL THAT IT IS MEDICALLY NECESSARY. IN THE EVENT MEDICARE SHOULD DENY PAYMENT, YOU WILL BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT TO THE PHYSICIAN. ALSO, I ACKNOWLEDGE THAT SOME OR ALL PATIENT INFORMATION MAY BE TRANSMITTED ELECTRONICALLY TO ALL APPROPRIATE PARTIES.

Signature_____ Date_____