Express Care Clinic/West Lincoln Family Medicine

201 Capital Beach Blvd, Suite 1A
Lincoln, NE 68528-1645
402-435-0228

PATIENT INFORMATION

Receipt of Notice of Privacy Practice

I have been offered or received a copy of Express Care Clinic/West Lincoln Family Medicine's Notice of Privacy Practices.

_____ _____ _____
Patient Authorized Signature | Relationship to Patient | Date

Message Authorization

Representatives of Express Care Clinic/West Lincoln Family Medicine are allowed to leave any and all information regarding my status as a patient on my voice mail, answering machine, or email account. I realize this information may include pertinent health status and/or financial information.

_____ _____ _____
Patient Authorized Signature | Relationship to Patient | Date

_____ _____ _____
E-mail Address | Home # (10 digit) | Cell # (10 digit)

Express Care Clinic/West Lincoln Family Medicine may communicate information to the following people regarding my health status as needed.

_____ _____ _____
Name | Phone Number (10 digit) | Relationship to Patient

_____ _____ _____
Name | Phone Number (10 digit) | Relationship to Patient

_____ _____ _____
Name | Phone Number (10 digit) | Relationship to Patient

☐ DO NOT leave a message (Check box if applicable)

_____ _____ _____
Patient Authorized Signature | Relationship to Patient | Date

MEDICARE PATIENTS ONLY

MEDICARE Authorization

I request that payment of authorized Medicare benefits be made either to me, or, on my behalf, to Express Care Clinic/West Lincoln Family Medicine for any services furnished to me by its physician. I authorize my holder of medical information to release to the Centers for MEDICAID and MEDICARE services and its agents any information needed to determine these benefits or the benefits payable for related services.

Secondary Insurance Benefits Authorization

I hereby authorize payment of my Medigap and/or Secondary Insurance benefits to Express Care Clinic/West Lincoln Family Medicine for all claims filed on my behalf. This authorization applies to all services until it is revoked by me or my representative.

_____ _____ _____ _____
Secondary Insurance Provider Name | Policy Name | Policy Number | Group Name

_____ _____ _____
Patient Authorized Signature | Relationship to Patient | Date