

# NORFOLK FAMILY MEDICINE INFORMATION SHEET

900 West Norfolk Ave., Ste 100  
Norfolk, NE 68701

*Please print*

**HEAD OF HOUSEHOLD**

Last Name \_\_\_\_\_  
 First & Initial \_\_\_\_\_  
 Preferred Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ M/F  
 Social Security Number \_\_\_\_\_  
 E-mail address \_\_\_\_\_

**SPOUSE** \_\_\_\_\_

Preferred Name \_\_\_\_\_  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ M/F  
 Social Security Number \_\_\_\_\_  
 Cell Phone \_\_\_\_\_  
 E-mail address \_\_\_\_\_

**EMPLOYER**

Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Work Phone Number \_\_\_\_\_

**EMPLOYER**

Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Work Phone Number \_\_\_\_\_

Church Preference

\_\_\_\_\_

**DEPENDENTS:**

First	Last	M/F	Birth date
_____	_____	_____	____/____/____
_____	_____	_____	____/____/____
_____	_____	_____	____/____/____
_____	_____	_____	____/____/____
_____	_____	_____	____/____/____
_____	_____	_____	____/____/____
_____	_____	_____	____/____/____
_____	_____	_____	____/____/____

**\*Please provide your insurance card(s) at each visit for photocopying.**

Nebraska law entitles both parents to medical information regarding dependents unless documented revocation of parental rights has been processed.

**\*If restrictions apply please provide documentation.**

**ASSIGNMENT AND RELEASE:** I hereby authorize my **INSURANCE BENEFITS** to be paid directly to the physician and understand that I am financially responsible for non-covered services. I also authorize the physician to release any information necessary to process insurance claims. (A photo-copy of this authorization will be considered valid.)  
 Should referral be made by the physicians at NFM for your continued medical care your signature below authorizes disclosure of pertinent medical records.

Signed \_\_\_\_\_  
 Print Name \_\_\_\_\_  
 Date \_\_\_\_\_

Spouse/Other Parent/Guardian \_\_\_\_\_  
 Print Name \_\_\_\_\_  
 Date \_\_\_\_\_

**SUBSEQUENT VISITS:**

**BY INITIALING AND DATING BELOW I CONFIRM THAT THE INFORMATION ON THE FRONT AND BACK OF THIS FORM IS CURRENT.**

INITIAL	DATE	INITIAL	DATE	INITIAL	DATE	INITIAL	DATE	INITIAL	DATE
____/____	____/____	____/____	____/____	____/____	____/____	____/____	____/____	____/____	____/____
____/____	____/____	____/____	____/____	____/____	____/____	____/____	____/____	____/____	____/____
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____/____	____/____	____/____	____/____	____/____	____/____	____/____	____/____	____/____	____/____

**PERSON TO CONTACT IN CASE OF AN EMERGENCY: (Outside of Residence)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**RELEASE OF MEDICAL INFORMATION:** (SUCH AS LAB AND X-RAY RESULTS). BY SIGNING BELOW I GIVE CONSENT FOR MY RESULTS TO be given to my spouse in my absence. This release will be valid for 6 months.

Husband's Name \_\_\_\_\_ Wife's Name \_\_\_\_\_  
Wife's signature \_\_\_\_\_ Husband's signature \_\_\_\_\_

**OKAY TO LEAVE A MESSAGE ON MY ANSWERING MACHINE OR VOICEMAIL Y / N**

**PLEASE CHECK:** \_\_\_\_\_

**PAYMENT POLICY:** I have read the payment policy printed on this form and agree to its requests.

**PAYMENT POLICY**  
**NORFOLK FAMILY MEDICINE**

In order to provide the best possible service for our patients, we have recently revised our payment policy. Please take note of our current policy and plan accordingly for future visits.

**FULL PAYMENT** is expected at the time of service for all services unless one of the following exceptions applies:

1. You have private insurance and have met your deductible for the current year. If you have a co-pay, we ask that you pay your co-pay at the time of service.

**NOTE:** We will file your charges with your primary insurance company as a service to you. You will need to follow-up with your insurance company in 2 to 3 weeks to make sure that the claim is received and is being processed. You will also need to make sure that you keep our office updated on any new insurance information to avoid denial of a claim.

2. Payment arrangements are made with our office **prior** to your visit with a medical provider.

**NOTE:** If your appointment is scheduled through the phone nurse and you cannot pay for your visit at the time of service, please ask to speak with the front office prior to your visit in regards to making arrangements for a payment plan.

3. You are on **Medicaid** and have shown the receptionist your card for the current month.

All outstanding private balances are subject to a finance charge of 1.33 % monthly.

If you make payment arrangements with the receptionist a payment must be made on your account every 30 days in order for your account to remain in good standing with NFM.

