Welcome to Lincoln Medical Education Partnership

We are excited to meet you and would like to personally thank you for choosing Lincoln Medical Education Partnership (LMEP) to be part of your medical home! We hope you find the following information helpful in preparing you for your first appointment.

We provide integrated medical and behavioral health services including preventative and wellness visits, acute and chronic illness management, as well as acupuncture and counseling services. As your medical home, we will care for you in the office, hospital, nursing home or home visits when appropriate. We provide x-ray, laboratory and a variety of in-office surgical procedures as well as complete maternity care, delivery of your baby and well-child visits afterward. We are also happy to organize any referrals and specialist care efficiently.

Lincoln Medical Education Partnership hours and appointments
Our clinic/behavioral health appointment hours are 8am – 5pm Monday – Friday by appointment. If you have a message for your medical team after hours, you can communicate by sending us messages through our online portal any time of day or night.

You Have the Right to:
- Receive services regardless of age, gender, race/ethnicity, disability, religion/spiritual beliefs, or sexual preference.
- Take part in your medical and/or behavioral health care and treatment decisions.
- Be told in advance about care and treatment, and of any changes in care and treatment that may affect your well-being.
- Privacy of all records, information shared, and personal information.
- Decide to stop receiving services without being punished.
- Be told of the reasons for not allowing you to receive any services.
- Be free from abuse and neglect.
- Be treated with respect and dignity.
- Request that your care be given by a different clinic/organization.
- Make a complaint, make recommendations, and tell someone about your concerns without unfairness or retaliation and to have those complaints and concerns addressed. Complaints and concerns may be filed with the LMEP Compliance Officer at (402) 327-6851, the LMEP President at (402) 327-6801 or with Nebraska Health and Human Services Regulation and Licensure at (402) 471-0316.
- Be free from transfer or discharge for no good reason.
- Be told prior to admission of any fees for care, treatment, or related charges.

What about emergencies?
We provide 24/7 on-call medical services. If you need non-life-threatening medical services after hours, please call our on-call physician at 402-483-4571.
If you are struggling with mental health concerns and need someone to talk to after hours, please call the CenterPointe Crisis Response Line at (402) 475-6695.
If you have a life-threatening medical or behavioral health emergency or severe injury, please call 911 or go to the nearest hospital/emergency department.

Patient Information:

Name _____ Birthdate _____
LAST *FIRST* *MIDDLE INITIAL*

Street Address _____Apt/Unit Number_____

City _____State _____ ZIP _____

Home Phone _____ Cell Phone _____Work Phone _____
Ok to text? Y or N

Email _____ Social Security # _____
FOR PORTAL COMMUNICATION

Patient's Employer _____ Occupation_____

Gender: ☐Male ☐Female ☐Transgender Male ☐Transgender Female ☐Other_____

Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Other _____

Preferred Language:☐English☐Spanish☐Arabic☐Vietnamese☐Other_____Ethnicity:☐Hispanic☐Non-Hispanic

Race:☐Caucasian ☐African-American ☐Native American ☐Asian Pacific Islander ☐Multi-Racial ☐Other_____

If a minor, please list:

Parent/Guardian Name(s) _____ Phone_____

Relationship to patient_____

Parent/Guardian Name(s) _____Phone _____

Relationship to patient_____

Guarantor Information (Correspondence)

How are you related to the patient? ☐Self ☐Spouse ☐Parent ☐Child ☐Other_____

Street Address _____Apt/Unit Number_____

City _____ State _____ ZIP _____

Home Phone _____ Cell Phone _____ Work Phone _____

Birthdate _____ Social Security # _____

Gender: ☐Male ☐Female ☐Transgender Male ☐Transgender Female ☐Other_____

Employer's Name _____

Emergency Contact (not in household)

Name:_____Phone:_____Relationship:_____

Insurance Information

☐I do not have insurance

☐I have insurance (front desk will need to scan your card)

Primary Insurance Company_____ Birthdate _____

Policyholder's Name _____ Relationship to Patient:☐Self☐Spouse☐Child☐Other

Gender: ☐Male ☐Female ☐Transgender Male ☐Transgender Female ☐Other_____

Insurance ID_____ Group ID_____

Secondary/Supplemental Insurance Company _____

Policyholder's Name _____ Relationship to Patient:☐Self☐Spouse☐Child☐Other

Gender: ☐Male ☐Female ☐Transgender Male ☐Transgender Female ☐Other_____

Insurance ID_____ Group ID_____

Please list the names & types of specialists you see (if any):

_____ _____

_____ _____

_____ _____

Preferred Pharmacy (name & location) **Preferred Hospital**

_____ _____

How did you hear about us?

☐Google ☐Social Media ☐Family/Friend ☐Physician referral ☐Other_____

- Please note that unless otherwise requested in writing, mail and telephone messages will be received at the home address and phone number listed under demographic information

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Adult Health Questionnaire

Over the past two weeks, how often have you been bothered by the following problems?				
	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				

Family History			
Family Member	Medical Condition	Age	Cause of death
Father			
Mother			
Siblings			
Children			
Extended Family			

Social History			
Home History	Who do you live with? Do you feel safe at home? ☐Yes☐No	**Education/Work History**	What level of school did you complete? Current occupation?
Sexual History	Sexual orientation? ☐heterosexual ☐bisexual ☐celibate ☐homosexual Multiple sexual partners? ☐Yes☐No	**Tobacco History**	☐Never used ☐Current use, since_____ ☐Past use, quit year_____ Please specify type (check all that apply) ☐cigarettes ☐chew ☐pipe ☐snuff ☐cigar ☐e-cigarette
Alcohol Use History	☐No/Never used ☐Yes, current use. # times per week:_____ #drinks each time:_____ Specify type:_____ (beer, liquor, wine)	**Recreational Drug Use History**	☐Never used ☐Current use, since_____ ☐Past use, quit year_____ Please specify type (check all that apply) ☐marijuana ☐cocaine ☐methamphetamine ☐opiates ☐other_____
Exercise History	Do you exercise regularly? ☐Yes ☐No	**Caffeine Use History**	Do you use caffeine daily? ☐Yes ☐No
Advanced care planning	Do you have a living will? ☐No ☐Yes, specify type:_____ Do you have a medical power of attorney? ☐No ☐Yes, who:		

Allergies (please list reaction)	

Do you have any additional medical conditions you think we should know about?	
Have you ever had a surgery, hospitalization or blood transfusion? Please list and include approximate date	

Please list all of your medications – prescription and over-the-counter
(Bring in all of your meds to your first visit)

Medication	Dose	Why do you take this medication?

Please select all that apply	Yes	No	
Have you ever been diagnosed with depression or anxiety?			
Have you ever been diagnosed with a cancer?			Type?
			Date, Location
Have you ever had a colonoscopy?			
Have you ever had a mammogram?			
Have you ever had a Pap smear?			
Have you ever had a bone density test?			
Appendix removed?			
Tonsils removed?			
Gallbladder removed?			
Tubal ligation or vasectomy?			

Immunization History	Yes	No
Did you receive childhood immunizations?		
Do you have your shot records?		
Tetanus booster shot?		
Pneumonia shot?		
Flu shot?		
Hepatitis B vaccine series?		

Women's Health questions

Age of first period:_____ Last period date:_____
Regular periods: ☐Yes ☐No
Birth control method:_____

# of pregnancies:_____ # of living children:_____
# of miscarriages:_____ # of abortions:_____
# of vaginal deliveries:_____
# of C- section deliveries:_____

Chronic Medical Conditions				**Psychiatric**		
Please select all that apply	Yes	No	Date		Yes	No
Asthma / COPD				Depression		
High blood pressure				Anxiety		
Diabetes				Sleep problems		
Thyroid problems				Alcohol abuse		
Heart disease				Drug abuse		
Other (list below)						

Review of Systems

General	Yes		No
Fevers			
Night sweats			
Weight gain		How much?	
Weight loss		How much?	
Exercise intolerance			

Eyes	Yes		No
Dry/irritated/painful eyes			
Vision changes			
Ever seen by eye doctor?		When?	

Ears/Nose/Mouth/Throat	Yes		No
Difficulty hearing			
Ear pain			
Frequent nosebleeds			
Nose/sinus problems			
Bleeding gums			
Snoring			
Dry mouth			
Mouth/teeth problems			

Cardiovascular	Yes		No
Chest pain			
Arm pain on exertion			
Shortness of breath – walking			
Shortness of breath – lying			
Palpitations			
Heart murmur			
Lightheaded on standing			

Respiratory	Yes		No
Cough			
Wheezing			
Shortness of breath			
Coughing up blood			
Sleep apnea			
Use a CPAP machine			

Gastrointestinal	Yes		No
Abdominal pain			
Nausea or vomiting			
Diarrhea			
Constipation			
Reflux			
Blood or black in stool			
Trouble swallowing			

Genitourinary	Yes		No
Loss of urine			
Difficulty urinating			
Blood in urine			
Increased frequency			
Incomplete emptying			

Musculoskeletal	Yes		No
Muscle pain			
Muscle weakness			
Joint pain			
Back pain			
Swelling in extremities			

Skin	Yes		No
Abnormal mole			
Jaundice			
Rash			
Laceration			
Growth/lesions			
Ever seen dermatologist?		Who?	

Neurologic	Yes		No
Loss of consciousness			
Weakness			
Numbness			
Seizures			
Dizziness			
Headaches/migraines			
Restless legs			

Psychiatric	Yes		No
Depression			
Anxiety			
Sleep disturbance			
Safe in relationship			
Alcohol/drug abuse			

Endocrine	Yes		No
Fatigue			
Hair loss			
Cold intolerance			

Allergic	Yes		No
Runny nose			
Itching			
Hives			

****The following information only pertains to patients utilizing our Acupuncture services****

The initial consult
This includes a comprehensive health history, evaluation, and treatment. Appointment time can vary but the first visit will normally take 60 – 90 minutes. Many patients have found the initial consult to be an excellent opportunity to ask questions about Traditional Chinese Medicine (TCM), get to know the provider/staff, experience how acupuncture feels and discuss how it may benefit their lives. A treatment plan for future visits will also be made at the time since it is personalized and based on your individual needs. Once you are an established patient, it is possible to make an appointment on relatively short notice – if you find yourself having a difficult day and we have an opening on the schedule.

Acupuncture and health insurance:
We ask that you contact your insurance provider to see if acupuncture is covered under your policy. We understand navigating insurance coverage can be difficult and hope this information will help you with questions for your insurance provider. Your initial consult may be covered since it is billed as a regular medical office visit. Any follow-up appointment coverage is specific to your plan and may include varying reimbursement rates with a maximum number of visits per year. There may be certain terms under which it is covered (i.e. only with Dr. Referral or letter) and we are glad to help with this type of documentation. If you still have questions about your insurance or our billing procedures, we encourage you to contact our billing department at **402-483-4571** and your call will be returned within two – three business days.

If your plan covers acupuncture:
Your out-of-pocket expenses will likely fall into one of two scenarios:

1. You will have a designated co-pay amount.
2. You will have an amount dependent on your deductible.

If your plan does not cover acupuncture but you have a health savings account:
The cost of your treatments will not apply to your deductible. Regardless of whether your plan covers acupuncture or not, you can use your FSA or HSA funds to cover the cost of your treatments.

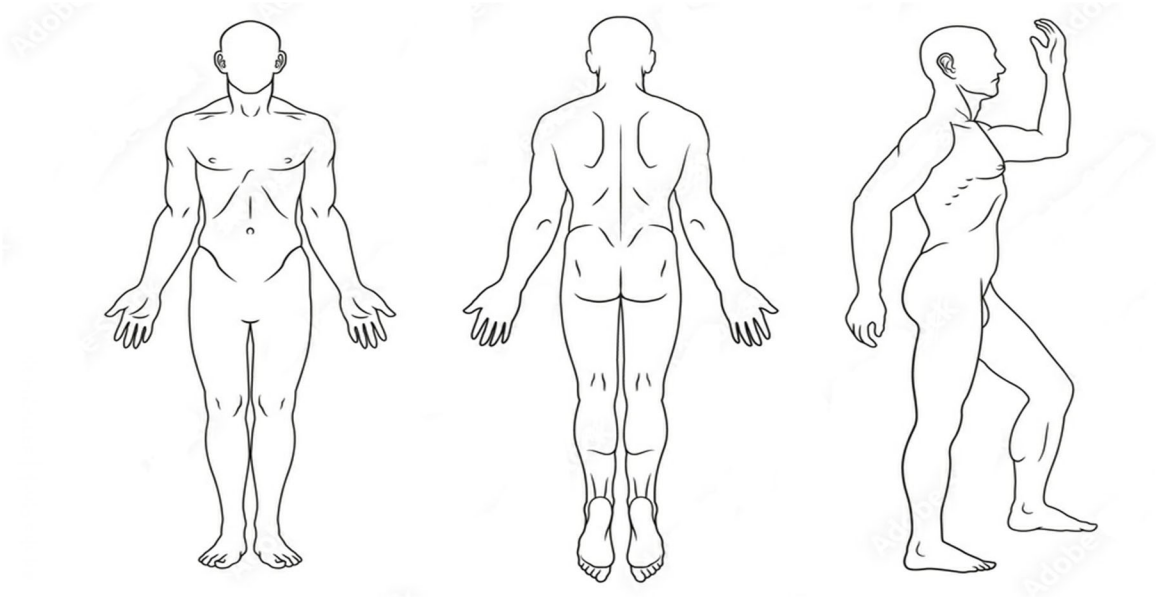
If you have no health insurance:
Our cash price at the time of service is $150 for initial consult and $99 for each follow-up visit.

Generally, patients feel better after their first treatment; however, we recommend that people give acupuncture at least 4 to 6 treatments for lasting effects. It will depend on how long you have had your symptoms as to how long it will take to see significant results. People also generally report resolution to many other conditions in addition to their “main complaint.” Likewise, it is helpful for people to have at least one treatment every week for one month to have the most benefit. Acupuncture has a cumulative effect, meaning that with each subsequent treatment, you may notice the effects lasting for a longer period of time.

Skip the next three pages if you are NOT here for Acupuncture services.

The next three pages are intended for Acupuncture patients only.

On the anatomical figures below, mark the area or areas where you have pain or other problems. Please be as accurate as possible with the locations.



Pain Assessment – Front	**Pain Assessment – Back**	**Pain Assessment – Side**
Location: Left/Right/Both	Location: Left/Right/Both	Location: Left/Right/Both
Onset:	Onset:	Onset:
Made better with: Made worse with:	Made better with: Made worse with:	Made better with: Made worse with:
Associated symptoms:	Associated symptoms:	Associated symptoms:
Quality: ☐Constant ☐Intermittent ☐Sharp ☐Dull ☐Pressure ☐Burning	Quality: ☐Constant ☐Intermittent ☐Sharp ☐Dull ☐Pressure ☐Burning	Quality: ☐Constant ☐Intermittent ☐Sharp ☐Dull ☐Pressure ☐Burning
Severity: 1 2 3 4 5 6 7 8 9 10	Severity: 1 2 3 4 5 6 7 8 9 10	Severity: 1 2 3 4 5 6 7 8 9 10

List in order of importance the problems you would like the doctor to treat.

1. _____
2. _____
3. _____
4. _____
5. _____

Please check any statements that apply to you **at least 80% of the time.** Be nonjudgmental and don't think about the answers too much. Leave blank any boxes that do not apply to you or that you are unsure of. There are no correct answers. **Your honesty will result in a better treatment plan.**

Shao Yin Fire		I can be characterized as creative, passionate, dramatic, and impulsive.
		I frequently ask due to heat and often feel flushed and sweaty.
		I tend toward sexual hyperactivity.
		I have experienced chest pains and palpitations.
		I tend to be talkative or noisy. I am the life of the party.

Tai Yang Fire		I can be characterized as authoritative, imposing, and impatient.
		I can be competitive. I like to win.
		I have neck or lower back pain.
		I have insomnia.
		I occasionally have headaches.

Tai Yang Water		I can be characterized as intelligent and hyper analytical but often indecisive.
		I have a history of recurrent urinary tract infections, urethritis, and kidney problems.
		I tend to have poor stamina and tire easily.
		I have diffused low back pain.
		I sometimes have digestive problems.

Shao Yin Water		I can be characterized as private, cautious, and secretive.
		I have problems with motivation, self-discipline, and making decisions.
		I tend to have her current sore throats, tonsillitis, kidney infections, or kidney stones.
		I tend to be chili with cold hands. I dislike cold.
		I experience lower back pain, knee pain, and achy joints when I am tired.

Jue Yin Fire		I can be characterized as irritable, anxious, and emotionally volatile at times.
		I tend to harbor grudges and have explosive anger.
		I get tension headaches or stress related headaches.
		I get muscle cramps and often have insomnia.
		I am sensitive to many foods. I get stomach cramps and diarrhea or slow digestion.

Shao Yang Fire		I can be characterized as clear thinking and decisive.
		When I get agitated, I can't sleep.
		I tend to grind my teeth and have tight jaws.
		I have muscle aches and cramps.
		I need to exercise, move, and stretch or I don't feel right.

Shao Yang Wood		I can be indecisive. I wish I were more self-confident.
		I am sensitive to ridicule or criticism.
		I have neck pain and shoulder tension. This can cause headaches.
		I tend to have lateral or side hip pain.
		I have digestive problems due to my gallbladder.

Jue Yin Wood		I can be characterized as timid or introverted.
		I am sensitive to caffeine, and I need it as a pick me up.
		I get migraine headaches and tension headaches.
		My palms tend to be sweaty requiring a handkerchief.
		I have sensitive eyes. I'm nearsighted.

Tai Yin Earth		I can be characterized as round and fleshy with full lips, calm, and peaceful.
		I often have abdominal bloating and diarrhea.
		I have had anemia and menstrual or fertility problems.
		I have varicose veins or cold feet.
		I take care of others even at my own expense.

Yang Ming Earth		I enjoy life, food, and drink. I am a pleasure seeker.
		I have been diagnosed with heartburn, gastroesophageal reflux disease (GERD), or peptic ulcer disease (PUD).
		I sometimes overindulge in food and drink. I can gain weight easily.
		I developed digestive problems during times of stress or anxiety.
		My mood can swing from pleasant to angry and irritable.

Yang Ming Metal		I have recurrent sinus infections, colds, and respiratory infections.
		I have poor digestion and experience stomachaches. I focus on my bowel habits.
		I tend to be thin.
		I have a strong belief in honor, duty, responsibility, and respect for the law.
		I tend to feel tired and a little sad. I get depressed easily.

Tai Yin Metal		I have a history of respiratory problems such as bronchitis, pneumonia, asthma, or COPD with cough and phlegm.
		I have constipation alternating with diarrhea or have been diagnosed with irritable bowel syndrome (IBS).
		I have skin problems and allergies.
		I am organized and methodical.
		I am honest and obey the rules.

I have tried these treatments:

☐Chiropractic ☐Injections ☐Massage ☐Physical Therapy ☐Psychotherapy ☐Other_____

Additional information that will be important for the doctor to know:_____

_____

_____

lincoln medical education partnership

Medical Record Release Authorization

Patient Name _____Date of Birth_____

SSN# _____Home Phone _____Cell Phone_____

Address _____City/State/Zip _____

Email Address _____

A) I hereby authorize records FROM:

Name _____

Address _____

City/State/Zip _____

Phone# _____Fax# _____

B) To be released TO:

Name _____

Address _____

City/State/Zip _____

Phone# _____Fax# _____

C) For the purpose of:

___Litigation

___Insurance

___Self/Personal Copy*

___Transfer or Continuity of Care

___Other _____

___Disability

___Work Comp

___Behavioral Health/ Substance Use

Subject to Fees

Date Range _____ to _____

- ❑ Physician Office Notes
- ❑ Immunizations
- ❑ Operative/Procedure Reports
- ❑ Other _____
- ❑ Cardiology/EKG Reports
- ❑ Lab/Path Reports
- ❑ Radiology
- ❑ Minimum Necessary

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules, including 42 C.F.R. Part 2. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

(Signature of Patient/Parent/Guardian or Authorized Representative) (Date)

This authorization will expire one year from the above date unless I specify an expiration date: _____

Fee Agreement

I agree to pay Lincoln Medical Education Partnership (LMEP) for any services received (i.e., medical, behavioral health, acupuncture). I understand it is my responsibility to understand my health plan benefits.
Outstanding balances may be turned over to debt collection. This would result in dismissal from ALL LMEP services, including dismissal of ALL family members (spouse and children).
I hereby authorize all insurance benefits to be paid to LMEP and I understand that I am responsible for any claims not fully paid by my insurance carrier. I further authorize my provider to release any medical information necessary to process this claim. **UNLESS PREARRANGED, PAYMENT IS DUE 30 DAYS FROM DATE OF BILLING.**

Receipt of Notice of Privacy Practices Acknowledgment

I hereby acknowledge that I was offered a copy of LMEP's Notice of Privacy Practices (HIPAA), which sets forth the ways in which my personal health information may be used or disclosed by LMEP providers, and outlines my rights with respect to such information.

Informed Consent of Treatment

As a patient of LMEP, I am authorizing LMEP to provide services for **myself / my minor child or ward.**

I understand the potential risks, such as the discomfort of discussing problems and making changes. Necessary treatment includes, but is not limited to services, care, diagnostic procedures, medical treatments, pathology services, radiology services or behavioral health services as the provider deems necessary.
I understand that records of my care containing Protected Health Information may be used or disclosed to facilitate treatment, payment, and healthcare operations, and in other circumstances as authorized or required by law and described in the LMEP Notice of Privacy Practices.

- Nebraska state law requires some exceptions to privacy that are important to psychological care.
- All Nebraska citizens are required to report any reasonable belief that a child, or vulnerable adult, has been subjected to abuse or neglect.
- Healthcare providers are also obliged to act if a patient is in danger of self-harm or of harming another person.

I understand that I have certain rights to access my record and to authorize their release to others when such disclosure is in my best interest.

- If a patient is under the age of 18 (for counseling services) or 19 (for medical services), these rights usually belong to the parent or legal guardian. Because privacy is so important in this type of care, a provider may sometimes ask the parent or legal guardian to grant these privacy rights to the patient. However, all significant safety-related concerns will immediately be disclosed to the parent/guardian. If the patient is my minor child or ward, I will discuss my privacy rights with the provider, **I may agree or not agree** to grant these rights to the minor patient.

_____ _____
Printed Patient Name Date

_____ _____
Patient / Parent / Legal Guardian Signature Date

Code of Conduct

In keeping with LMEP's intent to provide a safe and healthy environment, we ask that you please follow the policies listed below:

- No smoking/vaping is allowed in the buildings or on any property of LMEP, including the parking lots.
- Weapons are not allowed on LMEP property regardless of whether or not the person is licensed to carry the weapon. Weapons include, but are not limited to, handguns, firearms, explosives, and any knife with a blade longer than three inches.
- The use and/or possession of alcohol and illegal drugs are prohibited on LMEP property.
- Clients are responsible for any prescription or OTC medication that are within their possession.
- I understand that the use of threatening, physical or verbal abuse towards any LMEP staff is grounds for immediate dismissal from ALL LMEP services, including dismissal of ALL family members (spouse and children). This may also result in contacting Law Enforcement if necessary. LMEP may also end the patient-provider relationship due to medication fraud or misuse, forgery, or if it's determined that the patient-provider relationship is not mutually beneficial to provide optimal health.

Attendance Policy

The professional staff of LMEP are dedicated to their patient's treatment and to empowering their patients to be self-reliant and accountable. Attendance is extremely important for one's treatment.

Patients for whom missing appointments, late arrivals and late cancellations has become a pattern will be discharged from ALL LMEP services. This will also include dismissal of your immediate family members (spouse and children). If this occurs, a list of referral sources for follow up treatment will be provided to you and your family. A pattern is considered three occurrences in a row or three occurrences out of four appointments.

A "no show" occurs when:

- The patient does not call to cancel their appointment and then fails to come to their appointment
- The patient arrives 15 minutes or later than the scheduled appointment time
- The patient fails to provide at least one hours' notice when cancelling the scheduled appointment

We understand that situations may arise that make it difficult to attend every appointment and to do so on time. However, we need this to be the exception rather than the rule.

I have read, understand and agree to LMEP's Attendance Policy as described above.

_____ _____

Printed Patient Name Date

_____ _____

Parent / Legal Guardian Signature Date

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