



Office: 402-509-2555 Fax: 402-509-2600
Intake.NE@AtlasMedicalCare.com

NAME OF PATIENT: _____ Date of Birth: _____

SELECTION OF PRIMARY CARE PROVIDER AND MEDICAL CONSENT

I hereby request my medical care to be coordinated through Atlas Medical Nebraska ("Atlas") and for my medical care to be delivered by its network of independently contracted, licensed Primary Care Providers and Specialists ("Atlas Providers"). I designate my assigned Atlas Primary Care Provider as my only Primary Care Provider and authorize them to assist in monitoring and managing all aspects of my health care.

CHRONIC CARE MANAGEMENT (CCM) AND CARE PLAN OVERSIGHT (CPO)

To improve the quality of care I receive I agree to allow my Atlas Primary Care Provider to provide me with Chronic Care Management (CCM), Home Health and Hospice Care Plan Oversight (CPO) services and to be designated as my only CCM provider. I understand that these are non-face-to-face insurance covered services and Atlas may bill my insurance for these services and depending on my insurance, I may be responsible for a co-pay, co-insurance, or deductible. These services include: consultation, guidance in managing my chronic conditions, reviewing my medications, help with specialist referrals, DME equipment, and tests, receiving a plan of care with personal health goals, sharing e-records and coordination of care with other providers, 24/7 phone access to clinical staff, and working closely with my home health and hospice. I can refuse these services by opting out at the end of any month by notifying Atlas in writing.

FINANCIAL RESPONSIBILITY

I authorize Atlas to bill my insurance and for my insurance company to make direct payments to Atlas for medical services rendered by Atlas Providers. I accept full financial responsibility for payment of insurance mandated charges such as Deductibles, Copays, and Coinsurance. I am aware that the only bills I will receive from Atlas will be for Deductibles, Copays, and Coinsurance; Atlas will not bill me personally for any services denied by my insurance. I understand that it is my responsibility to continuously provide up-to-date Insurance information or select a cash payment plan with Atlas.

NOTICE OF PRIVACY PRACTICES

Atlas participates in Government Health Information Exchange (HIE) programs to which I can opt out at any time. Atlas may disclose my health information when required to do so by law. Medical information is considered private and confidential; however, I am aware, that in accordance with HIPAA Law, my information may be shared or disclosed verbally, electronically, and on paper as needed to others who are involved in my care and as needed for medical billing and/or care coordination. Additionally, I understand that Atlas may need to contact me or my designee directly regarding my care. To improve care coordination, I give my permission for Atlas to leave phone messages regarding my medical care/account information. I understand that this consent will remain valid until updated or revoked.

- Voicemail: Text Message: Email:

RELEASE OF MEDICAL RECORDS

I authorize the prompt release of my complete health record from all past and present healthcare providers to Atlas to be reviewed by Atlas Providers; this authorization for release of information covers all past and present medical records, unless otherwise specified, which may include records relating to communicable diseases and treatment of alcohol or drug abuse.

HOSPICE CARE AND HOME HEALTH CARE

I understand that if I request Hospice or Home Health Services my Atlas Primary Care Provider will remain designated as my Hospice or Home Health Attending Physician /Attending Provider (GV) unless I otherwise notify in writing.

TERMINATION OF CARE AND TRANSFER OF CARE

My Atlas Provider(s) reserves the legal right to terminate services, at any time, without cause, with (30) days prior notice and care coordination. I understand that I may terminate services immediately at any time for any reason but must notify Atlas in writing. I understand, that if I am receiving Mobile Provider Services that my assigned Atlas Provider may or may not remain as my Mobile Primary Care Provider if I change care facilities/communities or move from my current address. Furthermore, I understand that Atlas may change my assigned Atlas Provider to any other Atlas Provider at any time without prior notice.

My Signature below certifies that I have read, understand, and consent to all the terms and conditions listed above.

Signature of patient or Legal POA

Date



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Atlas Locations: [] Mobile: Omaha [] Mobile: Lincoln [] Other:

PATIENT REGISTRATION

First Name: Last Name: (MI):
DOB: Sex: M / F Patient Personal Cell:
Preferred Language: Race: Ethnicity: [] Non-Hispanic [] Hispanic
Social Security Number: Medicare Number:

PLACE OF RESIDENCE

Physical Address:
Mailing Address:
Optional: Community/Facility Name: Move-in Date: Room#

PAST PRIMARY CARE PROVIDER AND CURRENT SPECIALISTS

Primary Care Provider Name/Info: Phone #:
Specialist: Specialty: Phone #:
Specialist: Specialty: Phone #:
[] I AM ON Hospice (Hospice Company:)
[] I AM ON Home Health (PT/OT/Skilled Nursing) (Home Health Company:

DESIGNEE INFORMATION (Please fax verification of active POA/FPOA to our office)

[] I DO have a Medical Power of Attorney (MPOA) [] I DO NOT have a Medical Power of Attorney (MPOA)
MPOA or Primary Contact: Relation to Patient:
MPOA Primary Phone #: MPOA Email Address:
MPOA Mailing Address: City: State: Zip:
[] I DO have a Guarantor or Financial POA (FPOA) [] I DO NOT have a Guarantor or Financial POA (FPOA)
FPOA or Primary Contact: Relation to Patient:
FPOA Primary Phone #: FPOA Email Address:
FPOA Mailing Address: City: State: Zip:

PRIMARY INSURANCE (Medicare, Medicare/Medicaid Advantage, Commercial Plan) (Part B, Part C)

Insurance Provider and Plan Name:
Member ID#

SECONDARY INSURANCE (Medicare Supplement Plan, Medicaid, or "Medigap" Plan) (Part F, G, K, L, M, N, Etc)

Insurance Provider and Plan Name:
Member ID#



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CONSENT TO COMMUNICATE / LEAVE VOICEMAIL / TEXT MESSAGE / EMAIL

Patient Name _____ **Date of Birth** ____/____/____

Atlas may need communicate with those involved in the care of the patient to discuss patient care, report test results, appointments, referrals, and/or billing/insurance information. To protect patient privacy and follow federal guidelines we will NOT leave messages or discuss medical information with anyone except the patient or legal guardian without written permission.

I give my permission for Atlas and its Independent Providers to communicate with and/or leave information via Voicemail, Text Message, and/or Email regarding my medical care/account information to the following individuals listed below

I fully understand that this consent will remain valid until revoked in writing.

PRIMARY CONTACT (MPOA)
First Name: _____ Last Name: _____
Relation to Patient: _____
Phone Number (_____) _____ - _____ <input type="checkbox"/> Voicemail <input type="checkbox"/> Text Message
Email Address _____

SECONDARY DESIGNEE
First Name: _____ Last Name: _____
Relation to Patient: _____
Phone Number (_____) _____ - _____ <input type="checkbox"/> Voicemail <input type="checkbox"/> Text Message
Email Address _____

FINANCIAL INFORMATION ONLY DESIGNEE
First Name: _____ Last Name: _____
Relation to Patient: _____
Phone Number (_____) _____ - _____ <input type="checkbox"/> Voicemail <input type="checkbox"/> Text Message
Email Address _____

My Signature below certifies that I have read, understand, and consent to all the terms and conditions listed above.

Signature of patient or Legal POA

Date



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PATIENT MEDICAL HISTORY

Patient Name: _____ DOB ____ / ____ / _____ Height: _____(Inches) / Weight: _____(lbs)

ADVANCED DIRECTIVES (Check all that apply / Fax verification of advanced directives to our office)

[] Living Will [] Advanced Directive. [] DNR (Do Not Resuscitate). [] DNI (Do Not Intubate) [] DNH (Do Not Hospitalize)

ALLERGIES AND ALLERGIES TO MEDICATIONS (include reaction if known i.e. rash, trouble breathing, etc):

SOCIAL HISTORY

Former Profession(s): _____
Current smoker YES NO Year started _____ Year Quit _____ Pack/s per day: _____
Tobacco use YES NO Type: _____ (chew, pipe, cigar, etc)
Alcohol Use: YES NO Type: _____ Drinks per week _____
History of Illicit Drug use: _____

FAMILY HISTORY

Mother Living Deceased known health issues: _____
Father Living Deceased known health issues: _____
Other family members known health issues (state relation and health issues): _____

SURGICAL HISTORY

Heart Bypass/CABG Date _____ Cardiac (Heart) Stent Date _____
Heart Valve Replacement Date _____ Pacemaker Date _____
Defibrillator/ICD Placement Date _____ Tonsillectomy Date _____
Appendix Removal Date _____ Gall Bladder Removal Date _____
Hysterectomy Date _____ Cataract removal - Date _____ L / R / Both
Knee Replacement Date _____ L / R / Both Hip Replacement - Date _____ L / R / Both
Other Surgical History _____

HOSPITALIZATION HISTORY (Please list any hospitalizations in the past 12 months, Hospital name and reason)

Empty box for hospitalization history with horizontal lines for text entry.



DETAILED MEDICAL HISTORY BY SYSTEM

Patient Name: _____ DOB ____ / ____ / ____

<p>Eyes and Ears:</p> <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Blindness (R, L, or both eyes): _____ <input type="checkbox"/> Hearing loss <input type="checkbox"/> Other: _____ <p>Heart:</p> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Attack – (Year if known): _____ <input type="checkbox"/> Heart Failure <input type="checkbox"/> Aortic Stenosis <input type="checkbox"/> Heart Valve Problems <input type="checkbox"/> Angina <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Atrial Fibrillation (A-fib) <input type="checkbox"/> Irregular Heart Beats <input type="checkbox"/> Pacemaker <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Edema (swelling) <input type="checkbox"/> Other: _____ <p>Kidney and Urinary Tract:</p> <input type="checkbox"/> Recurrent bladder infections (UTI) <input type="checkbox"/> Chronic Kidney disease <input type="checkbox"/> Enlarged prostate <input type="checkbox"/> Prostate Cancer <input type="checkbox"/> Urinary incontinence <input type="checkbox"/> Kidney stones <input type="checkbox"/> Bladder Cancer <input type="checkbox"/> Other: _____ <p>Endocrine:</p> <input type="checkbox"/> Underactive Thyroid <input type="checkbox"/> Overactive Thyroid <input type="checkbox"/> Diabetes Type 1 (juvenile onset) <input type="checkbox"/> Diabetes Type 2 (adult onset) <input type="checkbox"/> Other: _____ <p>Musculoskeletal:</p> <input type="checkbox"/> Arthritis <input type="checkbox"/> Chronic back pain <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Gout <input type="checkbox"/> Other: _____ <p>Psychological:</p> <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other: _____	<p>Lungs:</p> <input type="checkbox"/> Asthma <input type="checkbox"/> COPD/Emphysema <input type="checkbox"/> Bronchitis <input type="checkbox"/> Frequent or recurrent Pneumonia <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Pulmonary Embolism (blood clot in lung) <input type="checkbox"/> Lung Cancer <input type="checkbox"/> Other: _____ <p>Gastrointestinal:</p> <input type="checkbox"/> Reflux/GERD/Heartburn <input type="checkbox"/> Ulcers <input type="checkbox"/> Irritable Bowel Disease <input type="checkbox"/> Liver Disease/Cirrhosis <input type="checkbox"/> Hepatitis <input type="checkbox"/> Gallbladder Disease <input type="checkbox"/> Colon Polyps <input type="checkbox"/> Diverticulosis/Diverticulitis <input type="checkbox"/> Blood in Stool <input type="checkbox"/> Constipation <input type="checkbox"/> Hernia <input type="checkbox"/> Colon Cancer <input type="checkbox"/> Other: _____ <p>Neurologic:</p> <input type="checkbox"/> Dementia (Type if known): _____ <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Seizure disorder/Epilepsy <input type="checkbox"/> Neuropathy <input type="checkbox"/> Migraines <input type="checkbox"/> TIA (mini-stroke) <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Tremors <input type="checkbox"/> Other: _____ <p>Vascular:</p> <input type="checkbox"/> DVT (blood clot in arms or legs) <input type="checkbox"/> Aneurysm <input type="checkbox"/> Peripheral Vascular Disease (Poor circulation) <input type="checkbox"/> Other: _____ <p>Other Health conditions:</p> <input type="checkbox"/> Anemia <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Lupus <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Skin Cancer <input type="checkbox"/> Other Cancer: _____
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MENTAL HEALTH QUESTIONNAIRE

Patient Name _____ Date of Birth _____ / _____ / _____

PHQ-9 Questionnaire	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things in the last 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless in the last 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much in last 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy in last 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite or overeating in last 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself or that you are a failure or have let yourself or family down in last 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television in last 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual in last 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead, or of hurting yourself in some way in last 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. How difficult have these made it for you to do your work, take care of things at home, or get along with other people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GAD-7 Questionnaire	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Feeling Nervous, anxious or on the edge in the last 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Over the past 2 weeks have you not been able to stop or control worrying?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Worrying too much about different things in the last 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Trouble relaxing in the last 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Being so restless that it is hard to sit still in the last 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Becoming easily annoyed or irritable in the last 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Feeling afraid as if something awful might happen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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CONSENT TO PHOTOGRAPH

I hereby authorize Atlas Medical, along with my Independent Primary Care Provider, Specialists, and other affiliated providers, to photograph, video record, or otherwise capture visual or audio documentation of me for the following purposes:

- o Medical Documentation: For inclusion in my medical records to support diagnosis, treatment, and care coordination.
- o Administrative Use: For internal operations, billing, compliance, and quality assurance.
- o Educational/Training Purposes: For staff education or training, with identifying information removed when appropriate.

I understand that:

- o These images or recordings will be stored securely and treated as confidential in accordance with HIPAA and applicable privacy laws.
- o I may revoke this consent in writing at any time, except where already relied upon.
- o This consent is voluntary, and refusal will not affect the care I receive.

I consent to being photographed or recorded under the conditions above.

(or)

I do not consent to being photographed or recorded.

My Signature below certifies that I have read, understand, and consent to all the terms and conditions listed above.

Signature of patient or Legal POA

Date