



575 S 70th Street, Suite 405 | Lincoln, NE 68510-2471 | Phone:402.483.7825 | Fax: 402.483.7839

PATIENT'S NAME (FIRST) (MIDDLE) (LAST)
MAILING ADDRESS CITY STATE ZIP
BILLING ADDRESS CITY STATE ZIP
TELEPHONE ( ) HOME / ( ) WORK / ( ) CELL AGE BIRTHDATE / /
EMAIL ADDRESS (optional)
OCCUPATION SSN MARITAL STATUS(circle) M D S W
EMPLOYER'S NAME & CITY/STATE
REFERRED BY FAMILY PHYSICIAN
EMERGENCY CONTACT (NOT LIVING WITH YOU) PHONE #
SPOUSE'S NAME PHONE #
POWER OF ATTORNEY OR LIVING WILL? YES / NO NAME & PHONE #

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY
POLICY OR I.D. # GROUP #
NAME OF POLICY HOLDER BIRTHDATE
SECONDARY INSURANCE COMPANY
POLICY OR I.D. # GROUP #
NAME OF POLICY HOLDER BIRTHDATE

IS THIS WORKER'S COMP OR PERSONAL INJURY RELATED? YES / NO DATE OF INJURY

I hereby authorize Lincoln Surgical Group, P.C. as the holder of medical or other information, to release to the Social Security Administration and Centers for Medicare and Medicaid Services or it's intermediaries or carrier or any other commercial insurance company, any information needed for this or future related claim(s). I hereby acknowledge and understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I authorize Lincoln Surgical Group, P.C. to administer medical treatment. I agree that a photocopy of this agreement shall be as valid as the Original.

I have received notice of this organization's privacy practices. DATE

Signature of Patient or Authorized Representative

Signature of Parent or Legal Guardian



575 S 70th St, Suite 405  
 Lincoln, NE 68510  
 (402) 483-7825

**General Surgery**  
 Zijun Hao, M.D.  
 Edmundo Rivera, M.D.  
 Charles D. Voigt, M.D.

**Burn/Wound Care/HBO**  
 Zijun Hao, M.D.  
 Edmundo Rivera, M.D.  
 Charles D. Voigt, M.D.

### Financial Policy

Thank you for choosing Lincoln Surgical Group, P.C. for your medical and surgical needs. We are committed to providing the best possible care. Please read and sign this Financial Policy.

**Insurance Patients:** We participate with Medicare, Medicaid, and many commercial payers/networks. Please call your insurance company to verify if we participate with your plan. We will file your claims to your insurance as a courtesy.

Please remember the following regarding insurance:

- Copays are due at the time of service and cannot be waived under our contracts. Multiple services/procedures can result in multiple copays on the same day.
- Your insurance is a contract between you and your insurance company.
- Not all services are a covered benefit with all insurance policies/groups.
- You are responsible for any balance due – copays, deductibles, coinsurance
- We may ask to pre-collect for surgical procedures – includes deductible & coinsurance.
- **High deductible health plans (HDHP) may require a \$50 copay for each appointment/procedure. Remaining balances will be billed to the patient.**
- Current insurance cards are required at time of appointment.
- If your policy requires a referral from your Primary Care Provider (PCP), this is your responsibility to obtain prior to the appointment.
- VA Care in the Community and Tricare require authorizations/referrals. We cannot initiate these for you. You must contact them prior to your first appointment.
- Correspondence to you from your insurance carrier **MUST** be returned to them. This may include coordination of benefits (COB), injury questionnaires, etc.
- All authorizations for surgery are obtained by our billing department for surgery/procedures

**Cash Pay Patients: A minimum of \$100 is due at the time of service. Any remaining balance will be billed to the patient. Any surgery must be pre-paid prior to scheduling.**

If you are unable to pay your balance in full, please contact us our billing department at 402-483-7946. We offer interest free payment plans and financial assistance applications for those who meet income criteria. To assist you in payment of your bill, we accept cash, check, money orders, Visa, MasterCard, Discover and American Express. Returned checks are assessed a \$25 fee.

*I have read the **Financial Policy** above. I understand and agree to the **Financial Policy**. I further agree, in the event of my non-payment, to pay the cost of an outside collection agency and/or court costs and any reasonable fees that should be required.*

\_\_\_\_\_  
 Patient/Responsible Party Signature

\_\_\_\_\_  
 Date

10.2025

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**I. MEDICAL HISTORY:**

**\*\*\*\*\*PLEASE ANSWER EACH QUESTION\*\*\*\*\***

A. Do you have any chronic illnesses (ie: heart, diabetes, etc)? No \_\_\_ If yes, please list.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

B. Operations (List surgery and year performed). No history of surgeries \_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

C. Serious injuries/hospitalizations not previously listed:

\_\_\_\_\_

D. Are you ALLERGIC to any medications? No \_\_\_ **If yes**, please list medication, date and type of reaction: \_\_\_\_\_

E. Have you ever had a blood transfusion? No \_\_\_ Yes \_\_\_ **If yes**, any reaction?

\_\_\_\_\_

F. Do you currently smoke? No \_\_\_ Yes, I currently smoke \_\_\_  
Number of packs you smoke per day? \_\_\_ How many years have you smoked? \_\_\_  
Have you **ever smoked**? No \_\_\_ Yes \_\_\_ Number of packs you smoked per day? \_\_\_  
How many years did you smoke? \_\_\_ When did you quit smoking? \_\_\_\_\_

G. Do you drink alcohol? No \_\_\_ If yes, quantity and how often? What type?

\_\_\_\_\_  
\_\_\_\_\_

**II. FAMILY HISTORY:**

	<b>AGE (if living)</b>	<b>HEALTH PROBLEMS</b>	<b>DECEASED (age/cause)</b>
Father	_____	_____	_____
Mother	_____	_____	_____
Sisters	_____	_____	_____
	_____	_____	_____
Brothers	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Is there any family history of cancer, high blood pressure, heart trouble, diabetes? Epilepsy, bleeding disorders or unusual reactions to anesthetics? No \_\_\_ If yes, please list family members, relationship and condition: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**III. OTHER MEDICAL HISTORY**

**\*\*\*\*\*PLEASE ANSWER EACH QUESTION\*\*\*\*\***

**CARDIOVASCULAR** – Do you now have or have you ever had trouble with your heart or blood vessels? (Stroke, dizzy spells, blood clots, heart attack, dropsy, high blood pressure, etc.)

No \_\_\_ If yes, please describe: \_\_\_\_\_

**UPPER GI** – Do you now have or have your ever had any trouble with stomach or digestion? (Difficulty swallowing, heartburn, belching, ulcers, special diet, stomach or gallbladder trouble)

No \_\_\_ If yes, please describe: \_\_\_\_\_

**PULMONARY** – Do you now have or have you ever had any trouble with breathing or lungs? (TB, chronic cough, emphysema, bronchitis, shortness of breath, coughing up blood, etc.)

No \_\_\_ If yes, please describe: \_\_\_\_\_

**LOWER GI** – Do you now have or have you ever had trouble with bowel functions?

(Diarrhea, constipation, blood in stool, hemorrhoids, etc.) No \_\_\_ If yes, please describe:

**RENAL/URINARY** – Do you now have or have you ever had trouble with kidneys or bladder? (Frequent urination, getting up at night, burning, pain, blood in urine, etc.) No \_\_\_ If yes, please describe:

**MUSCULOSKELETAL** – Do you now have or have you ever had any trouble with bones/joints? (Arthritis, severe fractures, leg cramps with walking, etc.) No \_\_\_ If yes, please describe:

**NEUROLOGICAL** – Do you now have or have you ever had any neurological problems?

(Stroke, seizure, headaches) No \_\_\_ If yes, please describe: \_\_\_\_\_

**ENDOCRINE** – Do you have any history of diabetes or thyroid problems or disease? No \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

**IV. FOR WOMEN ONLY – PREGNANCY HISTORY**

Number of deliveries: \_\_\_\_\_ Number of miscarriages: \_\_\_\_\_ Ages of Children: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Do your children have any significant health problems? No \_\_\_ If yes please describe:

Do you have difficulty with excessive/irregular periods or other female problems? No \_\_\_

If yes, please describe: \_\_\_\_\_

Age at menopause if applicable: \_\_\_\_\_

**Thank you!**

10/2025



## Meaningful Use Questionnaire

In order to comply with Federal regulations, Lincoln Surgical Group PC is required to ask these questions. They are asked to help enhance the quality, coordination and safety of your care among all your medical providers, now and in the future. We are enhancing our electronic health record (EHR) system in order to achieve these goals and to provide you, your referring physician, and your other medical providers (when requested) with your timely reports in a secure and confidential fashion. The Federal government will only receive summary reports of all patient totals, not your specific answers, which remain private.

### All questions must be answered

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Would you like access to our Health Portal to view your medical information?  YES  NO

Email to use for portal access: \_\_\_\_\_

### Would you like to receive reminders/notifications for:

Appointments  Lab Results  Health Maintenance  Rx confirmations  General Info

### How would you like to receive these reminders/notifications?

Voicemail  English  Spanish Number to call \_\_\_\_\_

Text/SMS  English  Spanish Number to use \_\_\_\_\_

Web Portal Only

Patient Opts out of all practice communication

### Preferred Pharmacy/Address (i.e. Hyvee - Lincoln @ Williamsburg)

\_\_\_\_\_

We will be using electronic prescribing which allows us to view the external history of your prescriptions. **Do You Approve (required to ask/answer)?**  Yes  No

### Please check the box next to the answer that best describes each category:

**Race:**  American Indian or Alaska Native  Asian  Black or African American  Native Hawaiian or Other Pacific Islander  Caucasian/White  Other Race  Refused to Report

**Ethnicity:**  Hispanic  Non Hispanic  Refused to Report

**Preferred Language:**  Arabic  Chinese  English  French  German  Hebrew  Hindi  Italian  Japanese  Korean  French  Portuguese  Russian  Spanish  Tagalog  Thai  Urdu  Vietnamese  Other \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Privacy Practices Policy

**Practice Name:** Lincoln Surgical Group PC

**Effective Date:** 02/16/2026

**Last Updated:** 02/05/2026

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## 1. Purpose

This Privacy Practices Policy describes how Lincoln Surgical Group PC, a small private **general surgery practice**, protects the privacy and confidentiality of patients' **Protected Health Information (PHI)** in accordance with the **Health Insurance Portability and Accountability Act (HIPAA)** and applicable federal regulations.

## 2. Scope

This policy applies to:

- All surgeons, clinical staff, administrative staff, contractors, and volunteers
- All PHI created, received, maintained, or transmitted by the Practice
- PHI in all forms, including electronic, paper, and oral communications

## 3. Definitions

- **Protected Health Information (PHI):** Individually identifiable health information relating to a patient's medical condition, surgical care, treatment, or payment.
- **Covered Entity:** A health care provider subject to HIPAA.
- **Business Associate:** A third party that performs services involving PHI on behalf of the Practice.
- **Minimum Necessary:** Accessing only the PHI required to perform job duties.

## 4. Policy Statement

Lincoln Surgical Group PC is committed to maintaining the privacy and security of patient information. PHI will be used or disclosed only as permitted or required by federal law.

## 5. Permitted Uses and Disclosures of PHI

PHI may be used or disclosed without patient authorization for:

### 5.1 Treatment

- Pre-operative, operative, and post-operative care
- Coordination with referring physicians, hospitals, anesthesiologists, pathology, imaging, and other providers involved in the patient's surgical care

### 5.2 Payment

- Billing, claims submission, collections, eligibility verification, and prior authorizations

### 5.3 Health Care Operations

- Quality improvement, case review, credentialing, compliance activities, training, and practice management

### 5.4 Legal and Regulatory Requirements

- Disclosures required by federal law, court orders, subpoenas, or government investigations

## 6. Minimum Necessary Standard

Workforce members must limit access to PHI to the minimum necessary to perform their assigned responsibilities. This standard does not apply to disclosures for treatment.

## 7. Patient Rights

Patients have the right to:

- Inspect and obtain copies of their medical records
- Request amendments to their PHI
- Receive an accounting of certain disclosures
- Request restrictions on uses or disclosures
- Request confidential communications
- Receive a copy of the Practice's **Notice of Privacy Practices**

- File a privacy complaint without retaliation

Requests must be submitted in writing and will be handled within HIPAA-required timeframes.

## **8. Notice of Privacy Practices (NPP)**

- The Practice maintains a **Notice of Privacy Practices** that explains how PHI is used and disclosed.
- The NPP reflects current federal HIPAA requirements, including **updates effective February 16, 2026**.
- The NPP is:
  - Provided to patients at first service
  - Posted in the office and on the Practice website (if applicable)
  - Available upon request

## **9. Safeguards to Protect PHI**

### **9.1 Administrative Safeguards**

- Designation of a **Privacy Officer**
- HIPAA training for all workforce members upon hire and annually
- Written procedures for privacy incidents and complaints

### **9.2 Physical Safeguards**

- Secured paper medical records
- Restricted access to staff-only areas
- Secure disposal of PHI (shredding or approved destruction)

### **9.3 Technical Safeguards**

- Secure electronic health record (EHR) system
- Unique user IDs and passwords
- Role-based access controls
- Encryption of electronic PHI where applicable

## **10. Breach Reporting and Notification**

- Any suspected or confirmed breach of PHI must be reported immediately to the Privacy Officer.
- The Practice will investigate all incidents and provide notifications as required under federal HIPAA breach notification rules.

## **11. Business Associates**

- All Business Associates (e.g., billing companies, EHR vendors, transcription services) must sign a **Business Associate Agreement (BAA)**.
- Business Associates are required to protect PHI in compliance with HIPAA.

## **12. Workforce Training**

- All staff receive HIPAA privacy training upon hire and annually thereafter.
- Training includes patient rights, safeguarding PHI, and breach reporting procedures.

## **13. Enforcement and Sanctions**

Failure to comply with this policy may result in disciplinary action, up to and including termination, and may result in civil or criminal penalties under federal law.

## **14. Policy Review**

This policy is reviewed at least annually and updated as necessary to reflect changes in federal law or practice operations.

## **Privacy Officer Contact Information**

**Name:** Melissa Rosene CPC

**Title:** Practice Manager

**Phone:** 402-483-7825

**Email:** info@lincolnsurgicalgroup.com