Revision Date: 07/22/2022

Pt # _____

ARTHRITIS CENTER OF NEBRASKA

Patient History Form

Advanced Directive Care Plan? ❑ Yes ❑ No

Date of first appointment: ____ /____ /____ (MONTH / DAY / YEAR) Time of appointment: _____ Birthplace: _____

Name: _____ (LAST / FIRST / MIDDLE INITIAL / MAIDEN) Birth date: ____ /____ /____ (MONTH / DAY / YEAR)

Address: _____ (STREET / APT #) Age: _____ Sex: ❑ F ❑ M

_____ (CITY / STATE / ZIP) Telephone: Home (____) _____ Cell (____) _____

MARITAL STATUS: ❑ Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse/Significant Other: ❑ Alive/Age _____ ❑ Deceased/Age _____ Major Illnesses _____

Spouse Occupation: _____

EDUCATION (circle highest level attended):

Grade school 7 8 9 10 11 12 College 1 2 3 4 Graduate school _____

Occupation _____ Number of hours worked/average per week _____

How did you hear about our clinic? ❑ Newspaper ❑ Internet ❑ Health fair ❑ Radio ❑ Arthritis lecture ❑ Other

Referred here by: (check one) ❑ Self ❑ Family ❑ Friend ❑ Doctor ❑ Other health professional

Name of person making referral: _____

Name of the physician providing your primary medical care: _____ Name of city the MD is located in: _____

Do you have an orthopedic surgeon? ❑ Yes ❑ No If yes, name: _____

Name of physician you will be seeing today _____

Describe briefly your present symptoms: _____

_____

_____

_____

_____

Date symptoms began (approximate) _____

Diagnosis: _____

Indicate below any previous treatment for this problem

(medications to be listed later):

Physical therapy _____

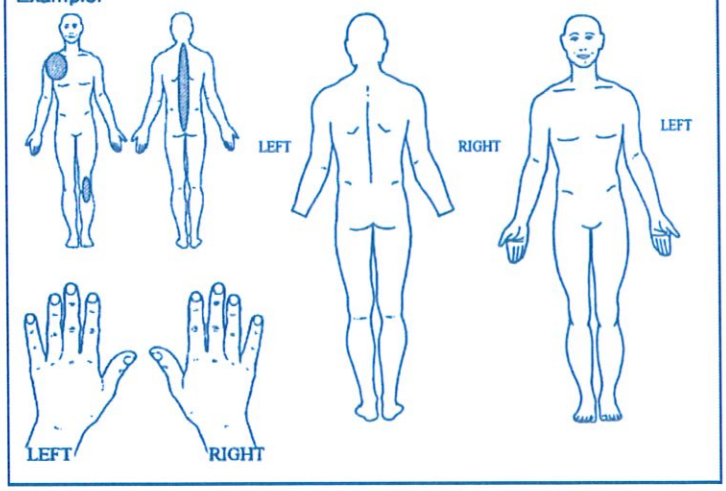
Injections _____

Surgery _____

Please list the names of the other practitioners you have seen for this problem: _____

Please shade all the locations of your pain over the past week on the body figures and hands.

Example:



RHEUMATOLOGIC (ARTHRITIS) HISTORY

At any time have you or a blood relative had any of the following? (check if "yes")

Yourself		Relative Name/Relationship	Yourself		Relative Name/Relationship
	Arthritis (unknown)			Lupus or "SLE"	
	Osteoarthritis			Rheumatoid arthritis	
	Gout			Ankylosing Spondylitis	
	Childhood arthritis			Osteoporosis	
Other arthritis conditions:					

Patient's Signature _____ Date _____ ACN Physician Initials _____

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what? _____

_____

Type of reaction: _____

CURRENT MEDICATIONS (Please write down all your medications even if you bring them with you to your appointment. Include such items as over the counter pain medications i.e. Tylenol, ibuprofen, aspirin, along with any vitamins, laxatives, calcium and other supplements)

Name of drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped? A lot	Some	Not at all
1.			❑	❑	❑
2.			❑	❑	❑
3.			❑	❑	❑
4.			❑	❑	❑
5.			❑	❑	❑
6.			❑	❑	❑
7.			❑	❑	❑
8.			❑	❑	❑
9.			❑	❑	❑
10.			❑	❑	❑
11.			❑	❑	❑
12.			❑	❑	❑
13.			❑	❑	❑
14.			❑	❑	❑
15.			❑	❑	❑

Have you participated in any clinical trials for new medications? ❑ Yes ❑ No

If yes list: _____

_____

PAST MEDICAL HISTORY

Do you now or have you ever had: (*check if "yes"*)

- ❑ Heart Problems
- ❑ High blood pressure
- ❑ Rheumatic fever
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Psoriasis
- ❑ Diabetes
- ❑ Goiter
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Colitis
- ❑ Jaundice/Hepatitis
- ❑ Stomach ulcers
- ❑ Anemia
- ❑ Cancer
- ❑ HIV/AIDS
- ❑ Severe headaches
- ❑ Seizure Disorder
- ❑ Nervous Breakdown
- ❑ Sleep apnea
- ❑ Asthma
- ❑ Emphysema
- ❑ Pneumonia (Hospitalized)
- ❑ Kidney Disease
- ❑ Clotting Disorders (Blood Clot, Lung Clots, Stroke)

Natural or alternative therapies (chiropractic, accupuncture, massage, over-the-counter preparations, etc.)

_____

_____

_____

Patient's Name _____ Date _____ ACN Physician Initials _____

SOCIAL HISTORY

Do you drink caffeinated beverages? ❑ Yes ❑ No
If yes, how many cups/glasses per day? _____
Are you a:
❑ Nonsmoker
❑ Current smoker ❑ Every day ❑ Some days, but not every day
How many cigarettes a day do you smoke? _____
How soon after you wake up do you smoke your first cigarette? _____minutes
Are you interested in quitting? ❑ Ready ❑ Thinking about it ❑ Not ready
❑ Former Smoker
How long has it been since you last smoked?_____
Do you smoke a pipe? _____
Do you chew tobacco? _____
Do you vape? _____
Do you use street/recreational drugs? ❑ Yes ❑ No
If yes, please list: _____
_____
_____

Did you have a drink containing alcohol in the past year? ❑ Yes ❑ No

If 'Yes': How often did you have a drink containing alcohol in the past year?
❑ Never ❑ Monthly or less ❑ 2 to 4 times a month
❑ 2 to 3 times per week ❑ 4 or more times a week

If 'Yes': How many drinks did you have on a typical day when you were drinking in the past year?_____

If 'Yes': How often did you have six or more drinks on one occasion in the past year?
❑ Never ❑ Less than monthly ❑ Monthly
❑ Weekly ❑ Daily or almost daily

Do you exercise regularly?❑ Yes❑ No
Type of exercise _____
Number of times per week ____ Length of time in min. ____

Hobbies _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? ❑ Yes ❑ No

Do you wake up feeling rested? ❑ Yes ❑ No

Previous surgeries

Type	*Year*	*Reason*
1.		
2.		
3		
4.		
5.		
6.		
7.		

Any previous fractures? ❑ No ❑ Yes Describe: _____

Any other serious injuries? ❑ No ❑ Yes Describe: _____

Any hospitalizations – other than surgeries? ❑ No ❑ Yes Describe: _____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at death	Cause
Father				
Mother				

Number of brothers living _____ Number of brothers deceased _____ / cause of death_____

Number of sisters living _____ Number of sisters deceased _____ / cause of death_____

Number of sons living _____ Number of sons deceased _____ / cause of death_____ Ages of each_____

Number of daughters living _____ Number of daughters deceased _____/ cause of death_____ Ages of each_____

Health of children: _____

Do you know of any blood relative who has or had: (check and give relationship)

❑ Alcoholism _____ ❑ Colitis_____ ❑ Psoriasis_____ ❑ Thyroid disease _____

❑ Asthma _____ ❑ Diabetes_____ ❑ Rheumatic fever_____ ❑ Tuberculosis_____

❑ Bleeding tendency _____ ❑ Heart disease_____ ❑ Seizures_____

❑ Cancer_____ ❑ High blood pressure_____ ❑ Stroke_____

Patient's Name _____ Date _____ ACN Physician Initials _____

SYSTEMS REVIEW

Mammogram ❑ No ❑ Yes ____/____ (MONTH YEAR) Eye Exam ❑ No ❑ Yes ____/____ (MONTH YEAR) Chest X-ray ❑ No ❑ Yes ____/____ (MONTH YEAR)

Tuberculosis Test ❑ No ❑ Yes ____/____ (MONTH YEAR) Bone Densitometry ❑ No ❑ Yes ____/____ (MONTH YEAR)

Influenza (Flu) Vaccination ❑ No ❑ Yes ____/____ (MONTH YEAR) Pneumonia Vaccination ❑ No ❑ Yes ____/____ (MONTH YEAR)

Tetanus (DTaP) ❑ No ❑ Yes ____/____ (MONTH YEAR) Shingles Vaccination ❑ No ❑ Yes Dose 1 ____/____ (MONTH YEAR) Dose 2 ____/____ (MONTH YEAR)

COVID Vaccination ❑ No ❑ Yes Dose 1 ____/____ (MONTH YEAR) Dose 2 ____/____ (MONTH YEAR) Last Booster ____/____ (MONTH YEAR)

Evusheld ____/____ (MONTH YEAR)

As you review the following list, please check any of those problems which have significantly affected you.

Constitutional

- ❑ Night sweats
- ❑ Change in weight
- ❑ Loss of appetite
- ❑ Fever
- ❑ Fatigue

Cardiovascular

- ❑ High blood pressure
- ❑ Chest pain

Dermatology

- ❑ New hair loss
- ❑ Allergy to sun
- ❑ Finger color change in cold
- ❑ Rash
- ❑ Psoriasis
- ❑ Hives
- ❑ Easy bruising
- ❑ Skin cancer

Endocrinology

- ❑ New thyroid problem
- ❑ Excessive thirst

ENT

- ❑ Dry eyes
- ❑ Dry mouth
- ❑ Hearing loss
- ❑ Mouth sores

Eye

- ❑ Eye redness & pain
- ❑ Loss of vision

Female Reproductive

- ❑ Contraception
- ❑ Menopause

Gastroenterology

- ❑ Nausea/Vomiting
- ❑ Heartburn
- ❑ Difficulty swallowing
- ❑ Diarrhea
- ❑ Blood in stool

Male Reproductive

- ❑ Penile discharge

Musculoskeletal

- ❑ Back pain
- ❑ Neck pain
- ❑ Legs cramps
- ❑ Fracture

Neurology

- ❑ Weakness
- ❑ New headache
- ❑ Tingling numbness hands
- ❑ Tingling numbness feet
- ❑ Loss of balance/falls

Psychology

- ❑ Feeling blue or depressed
- ❑ Difficulty with sleep
- ❑ Mental or physical abuse
- ❑ Worries or anxiety

Respiratory

- ❑ Shortness of breath
- ❑ Coughing up blood
- ❑ Painful breathing / pleurisy
- ❑ Cough

Urology

- ❑ Blood in urine

Number of:

____Pregnancies

____Deliveries

____Miscarriages/abortions

Ethnic origin

_____

Patient's Name _____ Date _____ ACN Physician Initials _____

PAST MEDICATIONS Please review this list of arthritis medications. As accurately as possible, try to remember which medications you have taken, **how long** you were taking the medication, the **results** of taking the medication and list any **reactions** you may have had. Record your comments in the spaces provided.

Drug names	Please check: Helped? A lot	Some	Not at all
Disease Modifying Antirheumatic Drugs (DMARDS)			
Abatacept (Orencia)	❑	❑	❑
Adalimumab (Humira)	❑	❑	❑
Adalimumab Atto (Amjevita)	❑	❑	❑
Anifralumab (Saphnelo)	❑	❑	❑
Apremilast (Otezla)	❑	❑	❑
Azathioprine (Imuran)	❑	❑	❑
Baricitinib (Olumiant)	❑	❑	❑
Belimumab (Benlysta)	❑	❑	❑
Certolizumab (Cimzia)	❑	❑	❑
Cyclophosphamide (Cytoxan)	❑	❑	❑
Cyclosporine / Tacrolimus	❑	❑	❑
Etanercept (Enbrel)	❑	❑	❑
Golimumab (Simponi)	❑	❑	❑
Hydroxychloroquine (Plaquenil)	❑	❑	❑
Infliximab (Remicade)	❑	❑	❑
Ixekizumab (Taltz)	❑	❑	❑
Leflunomide (Arava)	❑	❑	❑
Methotrexate (Rheumatrex)	❑	❑	❑
Mycophenolate mofetil (CellCept)	❑	❑	❑
Risankizumab (Skyrizi)	❑	❑	❑
Rituximab (Rituxan)	❑	❑	❑
Sarilumab (Kevzara)	❑	❑	❑
Secukinumab (Cosentyx)	❑	❑	❑
Sulfasalazine (Azulfidine)	❑	❑	❑
Tocilizumab (Actemra)	❑	❑	❑
Tofacitinib (Xelijanz)	❑	❑	❑
Upadacitinib (Rinvoq)	❑	❑	❑
	❑	❑	❑
	❑	❑	❑
	❑	❑	❑
	❑	❑	❑
	❑	❑	❑
Others			
Cortisone/Prednisone	❑	❑	❑
Glucosamine	❑	❑	❑
Herbal or nutritional supplements	❑	❑	❑
Gout medications			
Allopurinol (Zyloprim/Lopurin)	❑	❑	❑
Colchicine (Colcrys)	❑	❑	❑
Febuxostat (Uloric)	❑	❑	❑
Probenecid (Benemid)	❑	❑	❑

Please check: Helped? A lot	Some	Not at all
Non-Steroidal Pain Relievers		
Aspirin (including coated aspirin)	❑	❑	❑
Celecoxib (Celebrex)	❑	❑	❑
Choline magnesium trisalicylate (Trilisate)	❑	❑	❑
Diclofenac (Voltaren)	❑	❑	❑
Diclofenac + Misoprostil (Arthrotec)	❑	❑	❑
Disalcid (Salsalate)	❑	❑	❑
Diflunisal (Dolobid)	❑	❑	❑
Etodolac (Lodine)	❑	❑	❑
Fenoprofen (Nalfon)	❑	❑	❑
Flurbiprofen (Ansaid)	❑	❑	❑
Ibuprofen (Motrin / Advil)	❑	❑	❑
Indomethacin (Indocin)	❑	❑	❑
Ketoprofen (Oruvail)	❑	❑	❑
Meclofenamate (Meclomen)	❑	❑	❑
Meloxicam (Mobic)	❑	❑	❑
Nabumetone (Relafen)	❑	❑	❑
Naproxen (Naprosyn / Aleve)	❑	❑	❑
Naproxen/Esomeprazole (Vimovo)	❑	❑	❑
Oxaprozin (Daypro)	❑	❑	❑
Piroxicam (Feldene)	❑	❑	❑
Sulindac (Clinoril)	❑	❑	❑
Tolectin (Tolmetin)	❑	❑	❑
Other pain relievers			
Acetaminophen (Tylenol)	❑	❑	❑
Codeine/Hydrocodone (Vicodin, Tylenol 3)	❑	❑	❑
Fentanyl	❑	❑	❑
Oxycodone	❑	❑	❑
Oxycontin	❑	❑	❑
Tramadol (Ultram or Ultracet)	❑	❑	❑
Other:	❑	❑	❑
Osteoporosis medications			
Abaloparatide (Tymlos)	❑	❑	❑
Alendronate / Fosamax	❑	❑	❑
Denosumab (Prolia)	❑	❑	❑
Estrogen (Premarin, etc)	❑	❑	❑
Ibandronate (Boniva)	❑	❑	❑
Raloxifene (Evista)	❑	❑	❑
Risedronate (Actonel)	❑	❑	❑
Romosozumab (Evenity)	❑	❑	❑
Teriparatide (Forteo)	❑	❑	❑
Zoledronic Acid (Reclast)	❑	❑	❑

Please list supplements:

Patient's Name _____ Date _____ ACN Physician Initials _____

ACTIVITIES OF DAILY LIVING

I live in a (circle one): Home Town home Apartment Assisted living

Do you have stairs to climb? ❑ Yes ❑ No If yes, how many?_____

How many people in household? _____ Relationship and age of each _____

Who does most of the housework?_____ Who does most of the shopping? _____

Who does most of the yard work?_____

Please try to answer all of the following questions, answer exactly as you think or feel. There are no right or wrong answers. Check the one best answer for each question.

AT THIS MOMENT, are you able to:	Without **ANY** difficulty	With **SOME** difficulty	With **MUCH** difficulty	**UNABLE** to do
Dress yourself, including tying shoelaces, doing buttons?	0	1	2	3
Get in and out of bed?	0	1	2	3
Lift a full cup or glass to your mouth?	0	1	2	3
Walk outdoors on flat ground?	0	1	2	3
Wash and dry your entire body?	0	1	2	3
Bend down to pick up something from the floor?	0	1	2	3
Turn regular faucets on and off?	0	1	2	3
Get in and out of a car, bus, train or airplane?	0	1	2	3
Vacuum the house and do necessary yardwork?	0	1	2	3
Run errands and shop as you would like?	0	1	2	3
Get a good night's sleep?	0	1.1	2.2	3.3
Deal with feelings of anxiety or being nervous?	0	1.1	2.2	3.3
Deal with feelings of depression or feeling blue?	0	1.1	2.2	3.3

FOR OFFICE USE ONLY

1=0.33	**2=0.67**
3=1.0	**4=1.33**
5=1.67	**6=2.0**
7=2.33	**8=2.67**
9=3.0	**10=3.33**
11=3.67	**12=4.0**
13=4.33	**14=4.67**
15=5.0	**16=5.33**
17=5.67	**18=6.0**
19=6.33	**20=6.67**
21=7.0	**22=7.33**
23=7.67	**24=8.0**
25=8.33	**26=8.67**
27=9.0	**28=9.33**
29=9.67	**30=10.0**

HAQ SCORE =

How much pain have you had because of your condition OVER THE PAST WEEK?
Please indicate below how severe your pain has been **(0=No pain; 10=Worst Pain)**

_____Pain Score

❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
0	0.5	1.0	1.5	2.0	2.5	3.0	3.5	4.0	4.5	5.0	5.5	6.0	6.5	7.0	7.5	8.0	8.5	9.0	9.5	10.0

Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing? **(0=Very well; 10=Very Poorly)**

_____Global Score

❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
0	0.5	1.0	1.5	2.0	2.5	3.0	3.5	4.0	4.5	5.0	5.5	6.0	6.5	7.0	7.5	8.0	8.5	9.0	9.5	10.0

Rapid 3(0-30)
Cat:
HS=>12
MS=6.1-12
LS=3.1-6
R=<3

After you wake up, how long does it take you to limber up? AM stiffness:_____ (min or hours)

What is the hardest thing for you to do?_____

Are you receiving disability? ..... Yes ❑ No ❑

Are you applying for disability? ..... Yes ❑ No ❑

Do you have a.medically related lawsuit pending? ..... Yes ❑ No ❑

Patient's Name _____ Date _____ ACN Physician Initials _____

Arthritis Center of Nebraska
3901 Pine Lake Road, Ste 120
Lincoln, NE 68516-5497
402-420-1212

ARTHRITIS CENTER OF NEBRASKA

PATIENT ACCOUNT#_____ DR_____

Family Physician _____ Referred by _____

PLEASE PRINT CLEARLY with BLACK or BLUE pen

APPOINTMENT DATE _____

PATIENT NAME_____
First MI Last

**NAME PREFERRED TO BE CALLED _____

ADDRESS _____

CITY _____STATE_____ZIP_____

E-mail address _____

TELEPHONE #'s Home _____ Work _____ Cell _____

SEX □ Female □ Male □ Transgender Birth date ____/____/____ mo day yr Marital Status □ Single □ Married □ Widowed □ Divorced □ Separated □ Domestic Partner

SOCIAL SECURITY # _____

EMPLOYER _____

OCCUPATION _____ □ Full-Time □ Part-time

IN CASE OF EMERGENCY NOTIFY:

IF MARRIED-SPOUSE

NAME _____ Work _____ Cell _____ Birth Date ____/____/____ mo day yr

ADDITIONAL EMERGENCY CONTACT NOT RESIDING WITH YOU _____

Relationship to patient _____

Home _____ Work _____ Cell _____

**THE GOVERNMENT IS REQUIRING US TO COLLECT THIS DATA - Please answer BOTH questions below about Hispanic Origin and Race **

Are you Hispanic, Latino or Spanish in Origin? Please Note: Hispanic origins are not races.

- ☐ No, not of Hispanic, Latino or Spanish Origin
- ☐ Yes, Hispanic
- ☐ Yes, Mexican
- ☐ Yes, Mexican American
- ☐ Yes, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, Other

Please select your race:

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Other Race
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Other Pacific Islander
- ☐ Vietnamese
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan

Primary Language Spoken: _____

ARTHRITIS CENTER OF NEBRASKA

Melvin A. Churchill, MD
Kristin A. Twidwell, PA-C
Samone M. Wulf, PA-C
William J. Saalfeld, DNP
Rick C. Chatwell, MD
Karis A. Lange, PA-C
Kaila M. Steinkuhler, PA-C

Board Certified Rheumatologists Providing Comprehensive Rheumatologic Care and Osteoporosis Evaluation

Date_____

PLEASE NOTE

We are requesting the following information in order to better serve you and to ensure the proper routing of medical reports. Please complete the following using BLACK or BLUE INK:

*It is **very important** the doctor's first and last name be listed along with the city and state.

Patient Full Name (please print): _____

City, State (please print): _____, _____

DOB: _____

Family Physician: _____ _____ _____
(First Name) (Last Name) (MD, PA, NP)

City, State (please print): _____, _____

***If PA (Physician Assistant) - which Doctor does he/she practice under?**

_____

Pharmacy Preferences:

Local Pharmacy

_____ _____ _____
(Name) (Address-Example: 56th & Highway 2) (Phone #)

Mail Order Pharmacy

_____ _____ _____
(Name) (Address) (Phone #)

Thank you for taking the time to provide this information to our office.

ARTHRITIS CENTER OF NEBRASKA

Name: _____ **Date of Birth:** _____

1. PRIOR AUTHORIZATION/ REFERRAL FOR INSURANCE

I understand that it is my responsibility to obtain prior authorization and/or physician referrals if required by insurance carrier. I understand that if I am treated without authorization, I will be responsible personally for all or part of the cost of professional services.

AUTHORIZATION TO RELEASE AND CONSENT TO OBTAIN HEALTH INFORMATION

- **I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM**
- I hereby authorize photocopies of the Patient Information Form to be valid as the original. I understand I can withdraw this authorization at any time, by notifying this office in writing.
- I hereby authorize treatment of the above patient and agree to pay all fees and charges for treatment, procedures and tests (including testing for HIV (AIDS) and Hepatitis, **if ordered by provider**) regardless of insurance coverage or the pending of insurance processing.
- I hereby authorize the Arthritis Center of Nebraska Providers to view the external prescription history via the RxHub service for the patient listed above.
- I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

X_____ Date_____

Patient's or authorized person's signature (if not the Patient, relationship to the patient) _____

---

2. RELEASE OF MEDICAL AND BILLING INFORMATION

(Complete this section of this Form if you wish to allow family or others access to your Medical and Billing information.)

I, _____do hereby authorize personnel to release information concerning any and all diagnostic studies and findings contained within my clinic chart (whether performed here or elsewhere), my billing, insurance, or other account information to the family member(s)/ parties listed below:

Name_____**Relationship**_____**Phone #**_____

Name_____**Relationship**_____**Phone#**_____

Name_____**Relationship**_____**Phone#**_____

X _____ _____

Patient's or authorized person's signature **Date**

(Please note: This form is valid from the date signed until another form is requested by the patient.)

---

3. I AUTHORIZE THAT VOICE MESSAGES MAY BE LEFT ON MY PHONE(S). ☐ Yes ☐ No

X _____ _____

Patient's or authorized person's signature **Date**

---

4. ACKNOWLEDGEMENT PLEASE CHECK ONE AND SIGN:

☐ I acknowledge that I am aware of **Notice of Privacy Act Practices** & **decline** to be given a copy of the document.

☐ I request to be given a copy of the **Arthritis Center of Nebraska's Notice of Privacy Practices** document

X _____ _____

Patient's or authorized person's signature **Date**

Office Use Only: Copy given to patient	_____	_____	_____
	Staff Initials	**Date**	**Account Number**

ARTHRITIS CENTER OF NEBRASKA

Melvin A. Churchill, MD
Kristin A. Twidwell, PA-C
Samone M. Wulf, PA-C
William J. Saalfeld, DNP
Rick C. Chatwell, MD
Karis A. Lange, PA-C
Kaila M. Steinkuhler, PA-C

Board Certified Rheumatologists Providing Comprehensive Rheumatologic Care and Osteoporosis Evaluation

IMPORTANT NOTICE ABOUT YOUR INSURANCE AND PAYMENT POLICY

Please bring your insurance card(s) to your appointment.
****If not available at time of appointment, you will be rescheduled.**
If you have a change of insurance it is your responsibility to notify us.

❖ Medicare replacement plans (Medicare Advantage plans) – Please contact your insurance carrier to verify participation.

❖ **If you do not live in Nebraska** – Please contact your insurance carrier for participation status of the plans below.

We are participating providers (In network*) with the following insurance plans:

- Medicare Part B
- Blue Shield
- Coventry
- First Health
- Interplan Health Group/Accountable Health
- Midlands Choice
- Nebraska Medicaid Health Plans
- United HealthCare

*It is your responsibility to check with your insurance regarding participating (In network) status.

NOTE: We do not participate with United HealthCare Military & Veterans (Formally Tricare West Region), ChampVa or Tricare For Life - however we will file your claim and accept assignment. They will pay us directly and our office will do the appropriate adjustment and bill you for any balance.

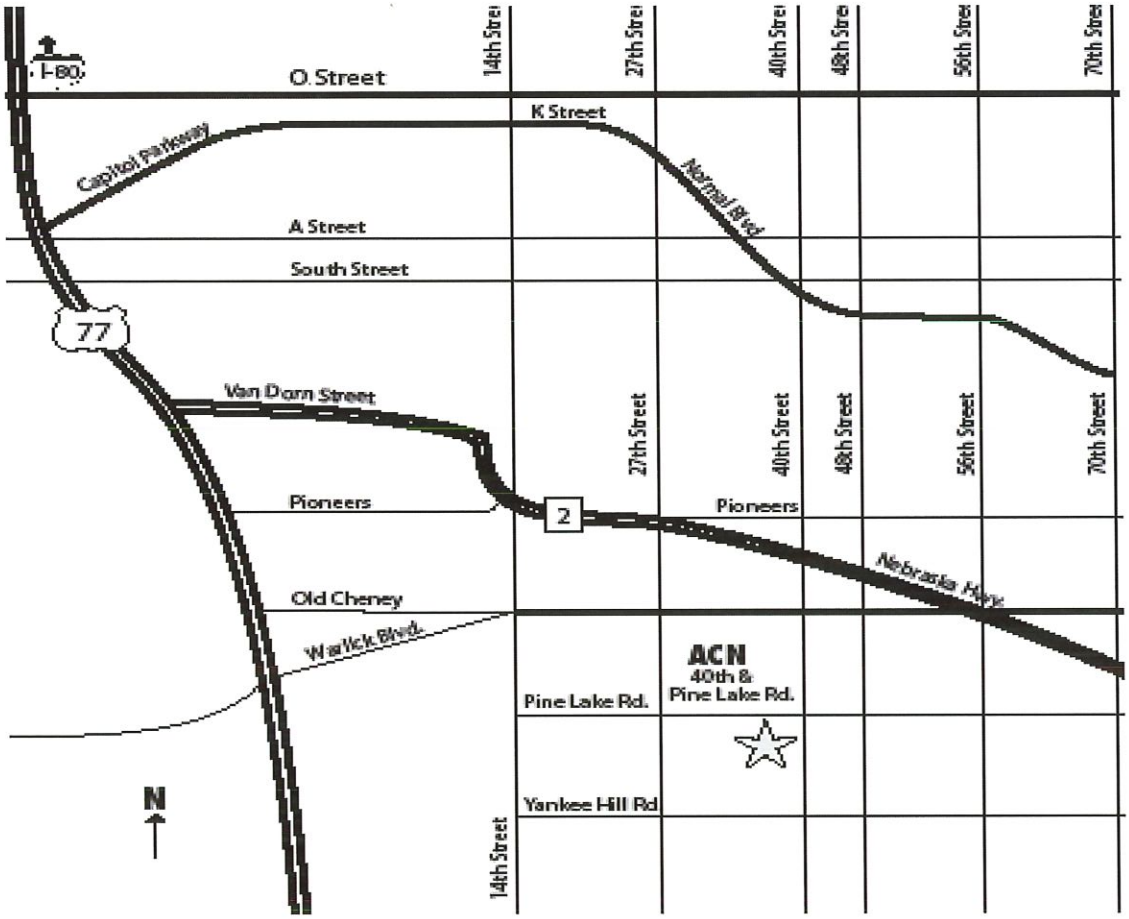
IMPORTANT INFORMATION REGARDING BILLING

- **Copays if applicable** – payment required at the time of your appointment.
- **Coinsurance or Deductible balance** – we will bill you when your insurance company processes your claim. You then have 30 days to pay this balance.

If you are unable to pay your balance within 30 days of receiving your 1st statement please call the Business Office at (402) 420-3400 to make payment arrangements.

Business Office Hours 7:00am-5:00pm M-Th & 7:00am-4:00pm Friday

3901 Pine Lake Road, Suite 120, Lincoln Nebraska 68516
Phone: 402-420-1212 Toll Free: 1-855-882-5310 Fax: 402-328-0961
www.nebraskaarthritis.com



Arthritis Center of Nebraska

Located in the Bryan Health Pine Lake Medical Plaza

(Southwest Corner of the Intersection of 40th and Pine Lake Road)

3901 Pine Lake Road Suite 120

Lincoln, NE 68516

402-420-1212

Toll Free 1-855-882-5310

Enter the main lobby on the west side of the building, turn right, and proceed straight ahead to our office

***If coming from the west on I-80** take Exit 397 (Hwy 77 bypass towards Beatrice) and go south to Old Cheney Rd. Turn left and go east on Old Cheney to 40th Street. Turn right onto 40th and go south to Pine Lake Rd. Cross Pine Lake Road – take first driveway on right – drive around to the main entrance on the west side of the building.

***If coming from the east on Hwy 2** – Take Hwy 2 to 40th Street. Turn left onto 40th and go South to Pine Lake Road (approximately 1 ½ miles). Cross Pine Lake Road – take first driveway on right – drive around to the main entrance on the west side of the building.

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