PRIMARY CARE PHYSICIANS, L.L.P.

12728 Augusta Avenue
Omaha, Nebraska 68144
(402) 330-1410

PATIENT NAME____

EHR #______________(Office Use Only) Age if Minor______________________

I. I hereby authorize Primary Care Physicians, L.L.P., Omaha, Nebraska, to furnish to the insurance company all information which said insurance company may request concerning my present illness or injury. Information may also be disclosed to the referring physician or to other health care providers, facilities or agencies that I may be referred to. I hereby assign to Primary Care Physicians, L.L.P., Omaha, Nebraska, the amount of money to which I am entitled for medical and/or surgical expenses for each claim submitted.

II. Notice of Privacy Practices
________ I acknowledge receipt of the Notice of Privacy Practices by signing below.

III. Billing and Payment Policy
________ I acknowledge receipt of the Payment and Billing Policy by signing below and agree to those conditions of payment.

IV. Please list the person(s) with whom we have your permission to discuss your medical condition, including the bills related to your medical care.

1. Name______________________ 2. Name______________________

Relationship______________________ Relationship______________________

Phone#______________________ Phone#______________________

3. Name______________________ 4. Name______________________

Relationship______________________ Relationship______________________

Phone#______________________ Phone#______________________

X______________________________ Date of Signing______________________
Signature of Patient

X______________________________ Time of Signing______________________
Signature of Patient's Representative (If minor)

______________________________ X______________________________
Please Print Name and Relationship to Patient — Witness Signature (Office Representative)