Rebecca Olander, PMHNP-BC, LLC
Shayla Hinrichsen, PMHNP-BC, LLC
Michael Purcell, PMHNP-BC, LLC
Paige Buresh, DNP, PMHNP-BC, LLC

Amanda Schnee, PhD, LLC
Carrie Semke, PhD, LLC
Casey Voichoskie, LIMHP, RPT, PC
Eryn McMaster, PhD, LLC
Alexandria Reznicek, LIMHP, LLC

5539 S. 27th Street, Suite 101, Lincoln, NE 68512
Phone: 402-261-6212 Fax: 402-817-4949

Patient Name (Last)_____ (First)_____ (Middle)_____
Address:_____ _____ Home Phone#: ( )_____-_____ Cell#: ( ) _____-_____
City: _____ State:_____ ZIP:_____
Date of Birth:_____/_____/_____ Soc. Sec#_____-_____-_____ Male: [] Female:[]
Race: _____ Ethnicity: [] Hispanic or Latino [] Not Hispanic or Latino Preferred Language: _____
Single: [] Married: [] Separated: [] Divorced: [] Widowed: [] Email: _____

Parent/Spouse's Name:_____ Soc Sec#_____-_____-_____
Date of Birth: _____/_____/_____ Email: _____

Purpose of Visit:_____
Referred By:_____ (Doctor name, Friend, Yellow Pages, etc.)
Primary Care Physician: _____Phone: ( )_____-_____
Emergency Contact: _____ Phone: ( )_____-_____

Do You Have Medical Insurance? Yes[] No[] (If Yes Please Answer **ALL** Questions Below)
Primary Insurance Company_____
Policy #_____ Group#_____
Does your insurance require authorization prior to the first session? Yes[ ] No[ ] If yes have you contacted the company? Yes[ ] No[ ]
Policy Holder's Name & Relationship_____
Policy Holder's Soc Sec#_____-_____-_____ Policy Holder's Date of Birth_____/_____/_____
Policy Holder's Employer's Name_____ Employer's Phone #: ( )_____-_____
Employer's Address_____

Secondary Insurance Company_____
Policy #_____Group #_____
Policy Holder's Name & Relationship_____
Policy Holder's Soc Sec #_____-_____-_____ Policy Holder's Date of Birth_____/_____/_____
Policy Holder Employers Name:_____ Employer's Phone ( )_____-_____
Employer's Address_____

Responsible Party or Guarantor (if other than patient): _____
Address: _____ Phone: ( ) _____-_____

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature of this document authorizes my provider to submit claims for benefits for services rendered for services to be rendered without obtaining my signature on each claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I authorize and assign payment of all/any insurance benefits to Encompass Care, LLC that is otherwise payable to me for his/her services as described on the assigned payment forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to individual providers will be credited to my account in accordance with the above assignment.

_____ _____ _____
(Print Name of Patient) (Authorized Signature of Patient/Parent/Guardian) (Date)

Note: If the patient is under the age of 19, their parent or guardian must sign all legal documents provided. *Revised 9/2022*