INNOVATIVE COMMUNITY HEALTH INSTITUTE, LLC
Saline Medical Specialties - 830 E 1st St. Suite 200 Crete, NE 68333
Lancaster Family Medicine - 4911 N 26th St. Suite 106 Lincoln, NE 68521

INNOVATIVE COMMUNITY HEALTH INSTITUTE, LLC (ICHI)
MEDICAL AND FINANCIAL CONSENT

Patient Name: _____ Date: _____

MEDICAL & FINANCIAL ACKNOWLEDGMENT:

Welcome to Innovative Community Health Institute LLC (ICHI). For patients without insurance, payment is due at the time of service: $100 for new patients and $100 for established patients. Discounts may apply for same-day payment. Accepted forms of payment include cash, check, and major credit cards. If you have active insurance, claims will be filed on your behalf; however, all copayments are due on the day of service. Coverage varies by plan, and you are responsible for any remaining balance after insurance processing. Work-related injury claims will be billed to the appropriate workers' compensation carrier or employer. For motor vehicle accidents or other third-party claims, full payment is required at the time of service. In cases of divorce or separation, the custodial parent is responsible for payment regardless of court orders. Separate bills may be issued by outside laboratories or imaging providers. Accounts over 30 days may be subject to collection activity.

TREATMENT CONSENT:

I consent to necessary medical, surgical, and diagnostic care provided by Innovative Community Health Institute LLC, and doing business as, Saline Medical Specialties, Lancaster Family Medicine, and its physicians and authorized providers. I understand that no guarantees have been made regarding treatment outcomes. I authorize ICHI to collect, use, and disclose my health information to entities involved in my care and to obtain my medication history electronically.

MEDICARE & INSURANCE AUTHORIZATION:

I authorize release of medical information necessary to process insurance and Medicare claims and assign benefits payable to Innovative Community Health Institute LLC. This authorization remains in effect until revoked in writing.

COMMUNICATION & MESSAGE PREFERENCES:

By providing my telephone number(s), I consent to receive calls or text messages from Innovative Community Health Institute LLC and its authorized representatives regarding appointments, treatment, and billing. Standard messaging rates may apply. I may update my contact information at any time.

If unable to reach me:

- ❑ Leave detailed medical message
- ❑ Request callback
- ❑ DO NOT LEAVE A MESSAGE

Messages may be left on:

- ❑ Home
- ❑ Work
- ❑ Cellphone

AUTHORIZATION TO SHARE INFORMATION: I give permission for ICHI to share my identifiable health information with:

1. Name: _____ Relationship: _____
2. Name: _____ Relationship: _____
3. Name: _____ Relationship: _____

NOTICE OF PRIVACY PRACTICES:

I understand that Innovative Community Health Institute LLC has a Notice of Privacy Practices describing how my medical information may be used and disclosed. I am entitled to receive a paper copy upon request, and ICHI may revise this notice at any time.

Patient or Authorized Signature: _____ Date: _____

Relationship: _____

Revised 1/2026