Family Wellness
at
FP Associates, P.C.
James A. Cervantes, MD

HEALTH SCREENING REGISTRATION

Name _____ Date of Birth _____
FIRST M.I. LAST

Address _____ Home Phone _____

City _____ State _____ Zip _____ Mobile Phone _____

e-mail _____

Bellevue University
[ ] Employee
[ ] Student – must show current student ID to receive any discounted services.

How did you hear about Family Wellness services? [ ] employer [ ] family/friend [ ] window signs

other: _____

Acknowledgment of **HEALTHCARE FOLLOW UP & MEDICAL MANAGEMENT RESPONSIBILITY**:
Please read and sign below:

I hereby acknowledge that it is my personal responsibility to follow up on abnormal lab test results and provide my healthcare provider with the results of my tests. I will maintain a copy of these lab test results and if I request an additional copy, there will be $10 fee to retrieve a copy for me. This fee will be waived if follow up healthcare is provided at FP Associates, P.C. Family Wellness screening and testing services do not establish a patient-physician relationship with any provider at FP Associates, P.C. I understand that I am welcome to become a patient by calling FP Associates, P.C. and request an appointment with James A. Cervantes, MD.

Acceptance of **FINANCIAL RESPONSIBILITY**:
Please read and sign below:

I hereby authorize payment directly to FP Associates, P.C. of the health screening services I have requested.
I understand that I am financially responsible for the amount of my bill and the charges will not be filed to my insurance.

I have read and agree to the above,

Signed _____ Date _____

1103 Galvin Road South, Suite F . Bellevue, Nebraska 68005 . 402-292-1072