Patient Registration Form

Today's Date _____ **SSN** _____ **DOB** _____

First Name _____ **MI**____ **Last Name** _____

Sex at Birth ☐ M ☐ F **E-Mail** _____

Address _____ **City** _____ **State/Zip** _____

Home Phone _____ **Cell Phone** _____

Work Phone _____ **Other Phone (list whose phone)** _____

Marital Status ☐ M ☐ S ☐ D ☐ W **Student Status** ☐ FT ☐ PT ☐ NO **Veteran Status** ☐Yes ☐ No

Sexual Orientation ☐ Straight (not lesbian/ gay) ☐ Lesbian/ Gay ☐ Bisexual ☐ Choose not to disclose

Gender Identity ☐ Male ☐ Female ☐ Transgender male (female to male) ☐ Transgender female (male to female)
☐ Choose not to disclose

Employment ☐ Full Time ☐ Part Time ☐Unemployed ☐ Retired

Patient employed by _____ **Occupation** _____

Spouse's Name_____ **Spouse's Employer** _____

Number in Household_____

Household Income Level ☐ $ 0- $12,000 ☐$ 12,000- $20,000 ☐ $ 20,000- $28, 000 ☐ $ 28,000- $40,000
☐ Choose not to disclose

Language ☐ English ☐ Spanish ☐Other_____

Race ☐ African American ☐ Asian ☐ Native American ☐ Native Hawaiian ☐ Pacific Islander ☐ White

Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino

You may be eligible for a discount on your medical or dental charges. Please ask to speak with the Financial Counselor for assistance.

Guarantor Information (If under the age of 18)

Insurance Policy Holders First Name _____**MI**____ **Last Name**_____

Relationship to Patient _____ **Employer** _____

DOB _____ **SSN** _____

Address _____ **City** _____ **State/Zip** _____

Home Phone _____ **Work Phone** _____

Emergency Contact _____ **Relation**_____

Phone _____ **This is a** ☐ Home ☐ Work ☐ Cell Phone

Does contact reside with patient? ☐ Yes ☐ No

If no, please list address _____

CONSENT TO TREATMENT

I,_____, voluntarily consent to outpatient care involving routine diagnostic procedures, examination, medical treatment including those procedures deemed medically appropriate by Healthy Connections, Inc. providers.

I authorize the clinic to release information to insurance carriers to process claims and authorize payment of medical benefits to the undersigned physician or supplier for services described below. I further authorize release of medical information to my medical providers or anyone I designate in writing. This Consent to Treatment remains in effect until I revoke in writing.

HIPAA Confirmation: I have had the opportunity to read and understand the Health Insurance Portability and Accountability Act policies in use by Healthy Connections, Inc.

PHOTOGRAPH: I hereby consent Healthy Connections, Inc. to photograph me (or my minor child) and relieve HCI of any responsibility for the use of my photograph for treatment, identification, and education purposes only.

ASSIGNMENT & RELEASE: I agree to assign directly to Healthy Connections, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the attending medical providers to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I understand that this consent form will valid and remain in effect as long as I (he/she) attend the clinic. This form has been fully explained to me and I understand its contents.

_____ _____

Patient Signature Date

_____ _____

Parent and/or Guardian Signature for Minor Child Date

____I understand that if my child is receiving treatment, I am signing this form on their behalf. As the responsible party of a minor child, I am consenting for my child to receive treatment at this clinic.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF **YOUR** HEALTH INFORMATION IS IMPORTANT TO US!

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy and security of your information. We must follow the duties and privacy practices described in this notice and give you a copy. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website (www.healthy-connections.org). You may request a copy of our Notice of Privacy Practices at any time, including any revisions of the Notices of Privacy Practices. For more information about our privacy practices, or for additional copies of this Notices, please contact us using the information listed below.

Healthy Connections, Inc., 136 Health Park Dr., Mena, AR. 71953

This notice effective date is **September 23, 2013.**

Uses and Disclosures of Health Information: We typically use or share your health information in the following ways:

- Treatment: We can use your health information and share it with other professionals who are treating you.
- Healthcare Operations: We can use and share your health information in to run our practice, improve your care, and contact you when necessary. Healthcare operations include but are not limited to quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
- Bill for your Services: We can use and share your health information to bill and get payment from health plans or other entities.

We are allowed or required to share your information in other ways-usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- Help with Public Health and Safety Issues: We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medications, and preventing or reducing a serious threat to anyone's health or safety.
- Abuse or Neglect: We may disclose your health information to appropriate authorities if knowledgeable disclosure of abuse or neglect is made to us or in instances where we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- Research: We can use or share your information for health research.
- Comply with the Law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy laws.
- Respond to Organ and Tissue Donation Requests: We can share health information about you with organ procurement organizations.
- Work with a Medical Examiner or Funeral Director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Address Workers' Compensation, Law Enforcement, and Other Government Requests: We can use or share health information about you for workers' compensation claims; for law enforcement purposes or with a law enforcement official; with health oversight agencies for activities authorized by law; and for special government functions such as military, national security, and presidential protective services.
- Respond to Lawsuits and Legal Actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

When it comes to your health information, you have certain rights. This sections explains your rights and some of our responsibilities to help you.

- Electronic or Paper Copy Access to Medical Records: You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge you a reasonable cost-based fee for expenses such as copies. You may also request access by sending a letter to the address listed below.
- Medical Record Correction: You can ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but you will receive an explanation in writing within 60 days.
- Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
- Limit What is Used or Shared: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- Listing of Those with Whom We've Shared Information: You can ask for a list (accounting) of the times we've shared your health information for the six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- Copy of Privacy Notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- Someone to Act for You: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- File a Complaint: If you feel your rights are violated, you can complain by contacting us at the address listed below and by phone at 479-437-3449 ask to speak with the Privacy Officer. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Right by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, tell us what you want us to do.

- Cases where you have both the right and choice: Share information with your family, close friends, or other involved in your care and share information in a disaster relief situation.
- Cases where we never share your information unless you give us written permission: marketing purposes, sale of your information, and sharing of psychotherapy notes. In the case of fundraising, we may contact you but you can tell us not to contact you again.

This notice applies to all Healthy Connections, Inc. clinics and outreach locations. **Address:** P.O. Box 1848, Mena AR 71953

I have received and/or reviewed a copy of the Notice of Privacy Practices.

Patient Name:_____ Date:_____
Guarantor's Signature:_____ Date:_____

I appoint the following individual(s) to act as my healthcare representative with whom my health information may be disclosed.

Name: _____ Phone Number: _____
Relationship: _____
Name: _____ Phone Number: _____
Relationship: _____
Name: _____ Phone Number: _____
Relationship: _____

You have the right to make changes in writing to this acknowledgement. You have the right to refuse to sign this acknowledgement. If you refuse to sign this acknowledgement we may be forced to refuse to administer treatment based on our inability to properly file your insurance and/or seek medical/dental/mental healthcare consultation and referral services.