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- $11,999 ☐$ 12,000- $19,999 ☐ $ 20,000- $27,999 ☐ $ 28,000- $39,999
☐ $40,000- 49,999 ☐ $50,000- $69,999 ☐ $70,000 and up ☐ 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 if 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 you 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 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 if 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 above 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 most 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.

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.

Prescription Medication Policy and Refill Request

- ***New Prescriptions will not be issued without first seeing your physician/provider***
- ***It is the responsibly of all Healthy Connections, Inc.'s (HCI) Patients to request refills of the HCI prescribed medications from patient's pharmacy.***
- Refills of medications prescribed by HCI providers require **72 hour advance notice to refill**. This give the pharmacy time to document the request and submit it to one of the Healthy Connections facilities.
- Upon receipt of the request from your pharmacy, an HCI ***medical clinician*** will review your medical record and determine if, A) You need to schedule an office visit prior to approving the prescription refill. B) You need additional testing prior to approving the prescription refill. C) The refill is approved without need for an office visit at this time.
- Upon determination by the medical clinician, A) You will be called to schedule an appointment with the medical provider or B) The approved prescription refill request will be sent to your pharmacy.
- REMEMBER, contact your pharmacy to check to see if your prescription is ready and ONLY after 72 hours from the time you first called your pharmacy has passed.
- If you change pharmacies, you MUST re-sign this form.

NO EARLY REFILLS WILL BE APPROVED

- **Schedule II Narcotic prescription (i.e., Morphine, Oxycodone, Fentanyl, etc.) refill requests require 5-7 days** to approve and MUST be picked up at the HCI reception desk. Only an original, hard-copy prescription will be accepted at your pharmacy according to state and federal prescription guidelines, refills will not be granted BEFORE 30 days have lapsed since your last refill date. Patients must have a current Pain Management agreement on file at HCI designating a local pharmacy.
- Our clinic **does not** provide pain management services. In some circumstances, we may prescribe a controlled substance/narcotic to a patient. We require you to provide us with names of any other medical/dental providers that you may have seen in the past year that has prescribed you this type of medication. We also require you to disclose the name of the pharmacy you will use. You, as part of your treatment, will be required to refrain from receiving this type of medication from any other providers during your course of treatment with us. **If we obtain information that you have filled or received a prescription from another provider during your treatment with us, we will contact the prosecuting attorney's office or local law enforcement and provide them with this information.** By initialing beside this policy, you give us the right to report this information. If you break this policy or do not disclose **all** information, we will terminate our physician/patient relationship.

My preferred pharmacy location is:

☐ Healthy Connections Community Pharmacy, Mena ☐ Medi Shop Pharmacy, Mena

☐ Woodard Family Pharmacy, Glenwood ☐ Mt. Ida Pharmacy, Mt. Ida

☐ Oak Park Pharmacy, Hot Springs ☐ Millers Drug Store, Malvern

I, _____, understand and will comply with HCI's prescription refill request policy. I understand that my prescription may be ready before 72 hours has passed, however, to ensure the highest level of patient care, it is important that I allow my medical provider adequate time to review my medical records and make the best decision for my health care.

_____ _____ _____

Signature Printed Name Date

___ I have prescription drug coverage through the following health plan _____

___ I DO NOT have a prescription drug plan medication benefit.

Plan Name: _____

(A copy of your prescription drug card must be provided to the front desk staff of HCI)

You will not be called by our staff. To check on your refill request. PLEASE contact your pharmacy.

MEMBER RIGHTS & RESPONSIBILITIES

Member Rights

1. You have a right to considerate and respectful treatment, regardless of race, creed, color, sexual orientation, national origin, disability, sex, religious preference, marital status, political beliefs, age or insurance status, in a manner showing dignity and respect regarding your personal values and belief systems.
2. You have a right to be seen at a time as close to your appointment as possible with the understanding that the needs of other patients will also be considered.
3. You have a right to seek care at Community Health Centers (CHC) and your payment will be based upon a sliding fee scale or other program eligibility.
4. You have a right to examine and to receive and explanation of your bill, regardless of the source of payment.
5. You have a right to have all physical examinations, interviews, and discussions take place privately and to have all communications and records about your care handled confidentially.
6. You have a right to know the names and the level of training of the providers who take care of you.
7. You have a right to the understandable explanation of what is wrong with you, the tests and treatments that are planned, and the risks involved in those tests and treatments.
8. You have a right to ask for another CHC provider's opinion or to ask that a new provider take charge of your case on a one-time basis.
9. You have a right to offer concerns or complaints about the health care received. Please ask for the Clinical Team Manager in the center.
10. You have a right to know that CHC does not perform any illegal forms of treatment.
11. You have a right to be informed about your treatment, diagnosis, and prognosis, and to accept or refuse health care advice or treatment.
12. You have a right to plan in advance for your health care and treatment, and to choose someone to make decisions for you, to the extent permitted by law, in case you become unable to make them for yourself.
13. You have a right to be informed of any clinical experimentation or other research/educational projects affecting your treatment and to refuse participation in such a experimentation or research.
14. You have the right to a timely response to your reports of pain and to have a clinically appropriate pain relief plan included in your health care plan.

Member Responsibilities:

1. You are responsible for conduct appropriate in a health care center. You may not verbally or physically abuse CHC personnel or property.
2. You are responsible for keeping your appointment at CHC, or notifying CHC in advance if you are unable to come to your appointment. If your appointment is missed or cancelled with less than 24 hours notice, you will be subject to a $25 no show fee.
3. You have the responsibility to provide accurate proof of your financial situation and to meet program requirements.
4. You have the responsibility to pay your portion of charges at the time of service.
5. You are responsible for questioning your provider about anything you do not understand about your care.
6. You are responsible for giving, to the best of your knowledge, accurate and complete information about complaints, past illnesses, medications, hospitalization and other matters relating to health care.
7. You are responsible for following the instructions given to you by your health care provider. You are responsible for the consequences of your own actions if you fail to follow these instructions, or if you refuse treatment.
8. You are responsible for telling your health care provider when you are in pain and join in your pain relief plan.

_____	_____	_____	_____
Patient Signature	Date	HCI Representative as Witness	Date

My signature above indicates I have read, understand, and will abide by the terms of the Members' Rights and Responsibilities for Healthy Connections, Inc.

Healthy Connections, Inc. is your ***Health Care Home*** –As a ***Patient Centered Medical Home (PCMH),*** we partner with our patients and engage in a relationship to strengthen and enhance the healthcare outcomes of those we serve. The Patient-Centered Medical Home* ("medical home") is a model of care that puts the needs of the patient first. The medical home is the base from which health care services are coordinated to provide the most effective and efficient care to the patient. This includes the use of health information technology, the coordination of specialty and inpatient care, providing preventive services through health promotion, disease management and prevention, health maintenance, behavioral health services, patient education, and diagnosis and treatment of acute and chronic illnesses.

-------Please complete the form below and return to the front desk staff-------

PATIENT NAME_____ SOCIAL SECURITY_____ DOB_____

Primary Care Provider Selection

____ I understand I have selected _____ as my primary care provider (PCP), and future appointments will be scheduled with him/her to ensure continuity and improved delivery of care. In the event that my provider is unavailable, my appointment may be scheduled with another provider. I understand I have the right to request a transfer to a different PCP in accordance with Healthy Connections, Inc.'s policy and procedures but that transferring to a new PCP will require completion of a new signed PCP document.

Medical

___ MENA – Terri Barrada, APRN

___ MENA – Joan Manzella, APRN

___ MALVERN- Melanie Newman, APRN

___ MALVERN- Larry Brashears, MD

___ MENA ST – Kristin Mack, APRN

___ MENA ST – Patrick Fox, MD

___ MENA ST – Carolin Hockersmith, APRN

___ ACORN – Gretchen Goodnight, APRN

___ MT. IDA – Jimmy Barrow, DO

___ MT. IDA – Julie Williams, APRN

___ MT. IDA/HOT SPRINGS – Mindy Gallegos, APRN

___ HOT SPRINGS - Michelle Greeson, APRN

_____ _____ _____

Patient's Signature Date Witness

_____ _____

Parent's Signature or Patient's Representative Date

Medication Record and Health History

List medications (both current and previously discontinued medications) and dates or mark N/A if no medications

Today's Date: _____ Name: _____ Date of Birth: _____
Age: _____ General Health: _____
Name and contact information of other physicians involved in you care:

_____

_____

Medication Name	Dosage	How Often do you take it

If more space is need, please ask front desk for another piece of paper.

Are you currently or have you ever been treated for

Yes	No	Condition	Explain
☐	☐	Allergies – Please list	
☐	☐	Asthma	
☐	☐	Bleeding Disorders	
☐	☐	Blood Pressure	
☐	☐	COPD	
☐	☐	Diabetes	
☐	☐	Ear/Sinus	
☐	☐	Fainting	
☐	☐	Gastro-intestinal Problems	
☐	☐	Heart Disease	
☐	☐	Kidney Disease	
☐	☐	Learning Disorders	
☐	☐	Menstrual Problems	
☐	☐	Musculo-skeletal	
☐	☐	Psychological/psychiatric	
☐	☐	Seizures	
☐	☐	Sickle Cell Disease	
☐	☐	Sleep Disorders	
☐	☐	Stroke	
☐	☐	Surgery – Please list	
☐	☐	Thyroid Disease	
☐	☐	Serious Injury	

Do you have a living will? ☐ Yes ☐ No Signature: _____

Medical and Dental Practice Patient Policies

- ☐ We require 24 hours prior notice if you are unable to keep your scheduled medical or dental appointment. Behavioral health appointments require 48 hour advance notice. We reserve the right to charge you a No Show fee and/or dismiss you from the practice if you fail to comply.

- ☐ Children may **not** be left alone in the waiting room and may **not** accompany you to the treatment/exam rooms. Please arrange for child care prior to your appointment or we reserve the right to reschedule your appointment.

- ☐ Only patients are allowed in the treatment area/rooms. If the patient is a minor, **one** parent or legal guardian will be allowed to accompany the patient to the treatment room, where the treating doctor will explain the diagnosis, planned treatment, and risks and benefits of the treatment. When it comes time to deliver the treatment/care to the patient, it will be at the discretion of the treating dentist/medical provider whether the parent or legal guardian will allowed to remain in the treatment/exam room for the remainder of the appointment.

- ☐ A parent or legal guardian is asked to escort/accompany special needs children and those 3 years of age and younger in the examination areas. Other children are **not** allowed in the treatment/exam rooms while a sibling is receiving care.

- ☐ Patent, legal guardian or nursing home staff **must** remain at the office during treatment/care if the patient is younger than 18 or is a resident or in the care of a group home, assisted living facility, nursing home, or any other type of guardian care.

- ☐ Cell phone use is **not** permitted in the treatment/exam rooms.

- ☐ Food and beverage is **not** permitted in the treatment/exam rooms.

- ☐ Please be considerate of others when talking. Patients who talk loudly or use inappropriate language may be asked to leave.

I understand and agree to conform to the above practice patient polies.
Print Name:_____ Date:_____

Patient/Legal Guardian Signature:_____

**HCI Providers reserve the right to deviate from this policy when in the best interest of the patient and the care being provided.*

AUTHORIZATION TO DISCLOSE/OBTAIN HEALTH INFORMATION

First Name	Middle Name	Last Name	Date of Birth / /	Today's Date
Address				
City	State	ZIP Code		
Home Phone ( )	Social Security Number	Please print any previous names under your records may be found:		
Are you transferring out of our facility? ☐ YES ☐NO				
I authorize Healthy Connections to: ☐**Obtain** my records from *or* ☐**Release** my records to:		**The purpose of this disclosure:** ☐Medical ☐Legal ☐Disability ☐Insurance ☐At the request of patient ☐Other		
Facility Name		Doctor's Name		
Address				
City	State	ZIP Code		
Phone ( )		Fax ( )		
The dates of service and type(s) of information to be used or disclosed are as follows: ☐Entire Record ☐History & Physical ☐Discharge Summary ☐ED Record ☐Psychiatric Intake & Eval. ☐Consultations ☐Billing Records ☐Laboratory Reports ☐Radiology Reports ☐Radiology Films ☐Psychosocial Assess. ☐Progress Reports ☐Other _____				

- This authorization will be valid for a period of one year from the date below. I understand that I may revoke this authorization at any time by notifying Medical Records in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.
- I understand that my treatment or continued treatment by Healthy Connections, Inc. is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.
- I understand this authorization is inclusive of ALL the information contained in my files. This may include alcohol, drug and psychological information. And any information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and any AIDS-related syndromes. It may also include information concerning cancer, cancer testing, and cancer results.
- I agree that a copy or a fax of this release shall be valid as the original release and release Healthy Connections from any liability for potential breach of confidentiality due to misdirection of transmission failure to receive transmission of my records.
- The parent or legal guardian must sign this authorization if the patient is a minor (under age 16) or has a legal guardian.
- Healthy Connections, its employees and providers are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.
- I agree to pay the copying cost, including other expenses allowed by law, such as the cost of any supplies, labor of copying, postage, or other expenses incurred by Healthy Connections to provide the copies requested I understand that I may inspect or copy the information to be used or disclosed.

I, the undersigned patient or legal representative, hereby authorize the use and disclosure of health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and HIV related information.

_____ _____ _____

Signature of Patient or Legal Representative **Date** **Time**

_____ _____ _____

Witness **Date** **HCI Provider**

Relationship to patient: ☐Self ☐Parent ☐Guardian ☐Conservator ☐Executor of Estate ☐Power of Attorney ☐Other_____

If signed by the Legal Representative attach appropriate documentation to verify authority

Please send all medical records to 479-437-3708 unless specified here _____