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 _____

How confident are you filling out medical forms by yourself? _____

1. Extremely **2.** Quite a bit **3.**Somewhat **4.**A little **5.** Not at all

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

I acknowledge that I have received a copy of Healthy Connections' Notice of Privacy Practices.

Guarantor's Signature:_____ Date:_____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

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

☐ Mt. Ida Pharmacy, Mt. Ida ☐ Woodard Family Pharmacy, Glenwood ☐ Oak Park Pharmacy, Hot Springs

☐ Millers Drug Store, Malvern ☐ Other _____

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, gender expression, gender identity, 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 Healthy Connections, Inc. (HCI) 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 HCI 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 HCI 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 HCI personnel or property.
2. You are responsible for keeping your appointment at HCI, or notifying HCI 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.

___ ACORN – Gretchen Goodnight, APRN

___ MENA – Terri Barrada, APRN

___ MENA – Joan Manzella, APRN

___ MENA – Sherilyn Webb, MD

___ MENA-- Eric Webb, PA

___ MENA ST – Patrick Fox, MD

___ MENA ST – Kristen Mack, APRN

___ MENA ST-- Carolin Hockersmith, APRN

___ MENA ST-- Eric Webb, PA

___De Queen -- Terri Devlin, MD

___ MCCC- Amy Stvartak, APRN

___ MCCC - Schasta Hibbs, 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.

- Patient, 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.*

FEE AGREEMENT AND FINANCIAL POLICY

Thank you for choosing Healthy Connections, Inc. Please review this Fee Agreement and Financial Policy, which describes charges not covered by insurance and additional fees. Please be sure you understand the policies regarding court advocacy and legal services, cancellations/missed appointments and non-sufficient funds. If you have any questions about anything, **please ask HCI staff prior to signing this Agreement and Policy**.

COURT ADVOCACY AND LEGAL SERVICES, THIS DOES NOT INCLUDE DIRECT PATIENT CARE, NOT COVERED BY INSURANCE CARRIERS

- Non-Patient Requested Medical Records $15.00 per request
- Indirect Services by a Licensed Provider (Medical or Behavioral Health)* $130.00 (pro-rated per 15 min.)
  Indirect services we provide outside our session times such as writing letters, consultations made at your request (for which a written authorization for disclosure of confidential information is required), coordinating adjunct and Court Advocacy services, and completing forms or reports. On occasion you may request that we testify or be present in court proceedings on your behalf of subpoena from the court the time billed will begin from our arrival at the courthouse to completion of testimony.
- Court Mandated Phone Consultations (11-60 min.) $130.00 (pro-rated per 15 min.)

ADDITIONAL FEES

- Late Cancellations/Missed Medical & Dental Appointment – fewer than 24 hrs. prior to appointment $25.00
- Late Cancellations/Missed Behavioral Health Appointment – fewer than 48 hrs. prior to appointment $25.00
- Non-sufficient funds (bounced) check $25.00

PAYMENT

You will be expected to pay for either each session in full, or your insurance co-payment at the time of services. Accepted methods of payment are cash, check, or credit cards. Checks should be made payable to *Healthy Connections, Inc.*

I have read the Agreement and Policy above. I understand the policy and by my signature below I agree to be bound by its terms in association with outpatient services provided to me by Healthy Connections, Inc. Any and all negotiated exceptions or special arrangements are listed below and require approval and are not valid unless signed by an authorized representative of Healthy Connections, Inc.

Patient name (printed) _____

Patient /Guardian signature: _____

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