PATIENT INFORMATION

Name (Last)_____ (First)_____(MI)_____

Password for HIPPA (any name or number)_____ Sex M F

Social Security Number_____Marital Status D M S W Date of Birth_____

Race: American Indian or Native American Asian Black or African American

Native Hawaiian White Other Race _____ Decline

Ethnic Group: Hispanic or Latino Not Hispanic or Latino Decline

Mailing Address_____City, State, Zip_____

Home Phone_____Cell_____Work_____

Employer_____Address_____

RESPONSIBLE PARTY

Name(First)_____(MI)_____(Last)_____

Relationship to Patient_____Date of Birth_____

Sex M F Social Security Number_____Marital Status D M S W

Home Phone_____Cell_____Work_____

Mailing Address_____City, State, Zip_____

Employer_____Address_____

INSURANCE INFORMATION

Primary Insurance Company_____

Group Number_____**Subscriber or I.D.** Number_____

Insured's Name/Policy Holder_____

Relationship to Patient: Self Spouse Dependent **Sex** M F

Insured's Employer_____Phone_____

Employer's Address_____City, State, Zip_____

Insured's Social Security #_____**Date of Birth**_____

Secondary Insurance Company_____

Group Number_____ **Subscriber or I.D.** Number_____

Insured's Name/Policy Holder_____

Relationship to Patient: Self Spouse Dependent **Sex** M F

Insured's Employer_____ Phone_____

Employer's Address_____ City, State, Zip_____

Insured's Social Security #_____ **Date of Birth**_____

EMERGENCY CONTACT INFORMATION

Person **LIVING** with Patient

Name(Last)_____ (First)_____ (MI)_____

Emergency Phone Number_____ Home_____

Cell_____ Work_____

Relationship to Patient_____

Address_____ City, State, Zip_____

Person **NOT** living with Patient

Name(Last)_____ (First)_____ (MI)_____

Emergency Phone Number_____ Home_____

Cell_____ Work_____

Relationship to Patient_____

Address_____ City, State, Zip_____

PHARMACY INFORMATION

Pharmacy Name and Location_____ Phone Number_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby assign, transfer and set over to Family Medical Associates, P.A. all of my rights, title and interest to my medical reimbursement benefits under my insurance policy with Medicare/Other Insurance Company. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Signature_____ Date_____

Chart Update

Name: _____ Date: _____
Contact Number: _____ DOB: _____

1. Do you experience any of the following symptoms: running nose, itchy nose, stuffy nose, itchy and/or watery eyes, or frequent sneezing? If you do, you may have allergies.

Is your medical history consistent with the symptoms above?
Yes No

2. Overall what is the severity of your allergy symptoms?
Mild Moderate Severe

3. Are your allergy symptoms present (please circle)
Rarely Seasonally (e.g. Summer/Spring only) ** Most of the year ***

4. Please circle the symptoms you suffer from and then circle the severity of the symptom(s).

a. Stuffy Nose	Mild *	Moderate **	Severe ***
b. Runny Nose	Mild *	Moderate **	Severe ***
c. Itchy Eyes	Mild *	Moderate **	Severe ***
d. Watery Eyes	Mild *	Moderate **	Severe ***
e. Itchy Throat	Mild *	Moderate **	Severe ***
f. Sneezing	Mild *	Moderate **	Severe ***

5. How often do you take prescription or over-the-counter medications for your allergies?
Not at all * Sometimes ** Frequently ***

6. Do you suffer from side effects such as dry mouth, drowsiness, or other effects?
Not at all * Sometimes ** Frequently ***

HIPPA COMPLIANCE INFORMATION

NOTICE OF PRIVACY PRACTICE

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.

THIS NOTICE IS EFFECTIVE 10/01/2005 AND CONTINUES UNTIL FURTHER NOTICE

RIGHT TO NOTICE

As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPPA), the office of Family Medical Associates, PA can use your protected health information for treatment, payment and health care operations.

a) Treatment-We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

b) Payment – We may use and disclose your health information to obtain payment for services we provide you.

c) Health care operations – We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvements activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION

Most uses and disclosures that do not fall under treatment, payment, health care operations will require your written authorization. It is the policy of this office to obtain a signed patient authorization before making a use or disclosure of protected health information. Upon signing you may revoke your authorization (in writing) through our practice at any time.

EMERGENCY SITUATIONS

In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare.

MARKETING

We will not use your health information for marketing communications without your written authorization.

APPOINTMENT REMINDERS

We may use or disclose your health information to provide you with appointment reminders via phone, e-mail or letter. Every effort will be made to protect your health information.

REQUIRED BY LAW

We may also use or disclose your health information when we are required to do so by law.

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 victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety.

NATIONAL SECURITY

We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

YOUR RIGHTS AS A PATIENT

You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or health care operations.

---You have the right to receive confidential communications regarding your protected health information.

--You have the right to inspect and copy your protected health information.

--You have the right to amend your protected health information.

--You have the right to receive an account of disclosures of your protected health information.

--You have the right to a paper copy of this notice of privacy practices.

LEGAL REQUIREMENTS

The office of Family Medical Associates PA is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted within our office.

COMPLAINTS

If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

CONTACT INFORMATION

For further information about the office of Family Medical Associates, PA privacy policies, please contact:

Family Medical Associates, PA
146 Hwy 32 2A
Ashdown, Ar 71822
870-898-5525

FAMILY MEDICAL ASSOCIATES, P.A.
CLINIC POLICY

In order to provide our patients with the best possible service in the most reasonable amount of time, the staff at Family Medical Associates requests your cooperation in implementing the following office policies:

Outpatient Tests/Procedures

Please notify the nurse if your insurance company requires you to use a particular facility or hospital.

Most insurance companies require pre-certification for outpatient testing. The pre-certification process can take up to 72 hours, as soon as the pre-certification process is complete, we will call you with your scheduled appointment. Please allow us 72 hours to complete the process, but if you do not receive a call from us after that time, please feel free to call.

Referrals

If your doctor desires that you see a specialist please understand that most specialists require us to fax a request along with your medical records and insurance information.
Once they contact us with your appointment time we will notify you. This process may take up to 72 hours depending upon the specialty.

Prescription Refills

Prescription refill requests will be reviewed by the doctor. Please allow 24 hrs for refills. Please check with your pharmacy before calling the clinic to see if your prescription has been refilled If there is a problem with your request we will notify you. Please call for a refill one week prior to running out of medication.

Phone Calls

If you need to speak to the nurse, please call the office and we will make every effort to return your call that day. Please understand the nurses and doctors are seeing patients and can only return phone calls in between patients and at the end of the day. Multiple calls further delay call back time. Calls after 4:00 p.m. will be returned the next day. If you have a medical emergency, please go to your local emergency room.

Test Results

Most lab results are returned to us within 48 hours of collection. The nurse will notify you of your test results, whether they are normal or abnormal, after they are interpreted by the doctor. If you have not received a phone call from us within 72 hours about your lab results, please call us.

Urine culture results typically take a week to return.

Outpatient tests such as an MRI, CT scan, or an echocardiogram may take longer as they are interpreted by other doctors at other facilities.

INSURANCE

Please be advised that when you become an eligible Medicare beneficiary, we may not be able to continue your care due to Medicare policies and reimbursement rates. Therefore, at that time, you may be required to choose a new primary care physician.

FAMILY MEDICAL ASSOCIATES, P.A.
146 HWY 32 2 A
ASHDOWN, AR 71822
PHONE: 870-898-5525
FAX: 870-898-8572

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask any questions you may have, and sign in the space provided. A copy will be provided upon your request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. ALL co-payments and deductibles **MUST** be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If

your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full, or establish a payment plan. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency; you will be responsible for any fees incurred in this process (i.e. collection agency fees, attorney fees), and you and your immediate family members will be discharged from this practice. At this time, our physician will **only** be obligated to treat you for 30 days on an emergency basis .

8. Divorce Decrees: This office is NOT a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.

9. Minor Patients: The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard, or payment by cash or check at the time of service has been verified.

10. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

I have read and received a copy of the HIPPA Notice of Privacy Practices.

I have read and received a copy of the Family Medical Associates, P.A. Clinic Policy concerning outpatient testing, referrals, prescription refills, test results, phone calls, and insurance.

_____ _____

Signature of patient or responsible party **Date**

Family Medical Associates P.A.
146 Hwy 32 2A
Ashdown, AR 71822
Phone (870)898-5525
Fax (870)898-8572

CONSENT FOR RELEASE OF MEDICATION INFORMATION

I authorize the release of medication information to Family Medical Associates, P.A. as stated below.

Please **check one** of the following

_____ I authorize release of all medication information past and present to Family Medical Associates, P.A.

_____ As **Parent/Guardian** of said minor, I authorize release of all medication information past and present to Family Medical Associates, P.A.

_____ Restricted Consent. I authorize release of medication information as prescribed by Family Medical Associates, P.A. only. I do not authorize access to any medication prescribed by any physicians other than a Family Medical Associates, P.A. physicians.

_____ _____

Print **Patient** Name

Patient Signature
Parent/Guardian Signature if Patient is Minor