AUTUMN ROAD FAMILY PRACTICE

Patient Information **Date: _____/_____/______**

Name: ______________________________ **Date of Birth:** ______________________
Address: ____
◯ Male ◯ Female ◯ Child ◯ Single ◯ Widowed ◯ Divorced
Home Phone: ______________ **Cell Phone:** ______________ **Work Phone:** ______________
Email address: ______________________ **Social Security Number:** ______________________
Employer: ______________________ **Occupation:** ______________________
Work Address: ____
Primary Language: ______________ **Race:** ______ **Ethnicity: ◯ Hispanic/Latino ◯ Not Hispanic/Latino ◯ Decline to Answer**

If under 19 years old

Father/Guardian: ______________________
Employer: __________ **Occupation:** __________
Address: ◯ Same as Patient
____
____
SSN: ______________ **DOB:** ______________

Mother/Guardian: ______________________
Employer: __________ **Occupation:** __________
Address: ◯ Same as Patient
____
____
SSN: ______________ **DOB:** ______________

Person to bill: ____

Other Contact Information

Emergency Contact Name: ______________________ **Relationship:** ______________
Address: ____
Home Phone: ______________ **Cell Phone:** ______________ **Work Phone:** ______________

Insurance Information

Primary Insurance: ______________________
Address to send claim: ______________________
____
Phone: ______________________
ID / Policy Number: ______________________
Group Number: ______________________
Insured's Name: ______________________

Secondary Insurance: ______________________
Address to send claim: ______________________
____
Phone: ______________________
ID / Policy Number: ______________________
Group Number: ______________________
Insured's Name: ______________________

If you have a third insurance, please write the information on the back of this form.

How did you hear about us? ◯ Family Member ◯ Friend / Acquaintance ◯ Online—Where? ______________
◯ Another Physician ◯ Insurance List ◯ Drive by ◯ Other: ______________________________

I hereby authorize payment directly to Autumn Road Family Practice, P.A. of the benefits otherwise payable to me. I authorize Autumn Road Family Practice to release any information concerning my healthcare, advice, treatment, or supplies provided. The information is to be used in administering claims and/or discussing treatment options with other medical professionals. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered.

I understand that this authorization will remain in effect for as long as my dependents or I remain under the care of Autumn Road Family Practice.

Signature: ______________________________ Date: ______________________

AUTUMN ROAD FAMILY PRACTICE

History & Physical **Date: _____ / _____/ _____**

Patient Name: ____ DOB:_______/_______/_______
Previous or referring physician: ____
Pharmacy Name: ____

REASON FOR VISIT: ____

Please provide the most recent month/year of the following screening tests:

Exam	Year / Provider or Location
Bone Density Testing	
Colonoscopy	
Physical Exam with Labs	
Prostate Exam or PSA	
Mammogram	
Pap Smear	

Please list your medical history: Diagnosis, Disease, etc. ____
____
____

Surgeries (Not including pregnancies)

Year	Illness or Operation	Surgeon or Provider	Year	Illness or Operation	Surgeon or Provider

Have you every consumed:
Cigarettes ◯ Yes ◯ No Packs per day: ________ Number of Years ________
Alcohol ◯ Yes ◯ No Drinks per week: ____________
Drugs ◯ Yes ◯ No If yes, specify: _____________________________________

Are you allergic to any medications? ◯ **Yes** ◯ **No**

Name of Medication	Type of Reaction	Name of Medication	Type of Reaction
1.		3.	
2.		4.	

Current Medications (include prescriptions, over-the-counter, and herbal)

Name of Medication	Dose	Frequency	Name of Medication	Dose	Frequency

Have any of your FAMILY (blood relatives) had any of the following conditions? If so, who?

Condition	Yes	No	Relation	Condition	Yes	No	Relation
Anemia/Bleeding Disorder				**Heart Disease/Heart Attack**			
Anxiety/Depression				**High Cholesterol**			
Other Mental Illness				**High Blood Pressure**			
Arthritis				**Kidney Disease**			
Asthma				**Migraines**			
Cancer				**Stroke**			
Congestive Heart Failure				**Seasonal Allergies**			
COPD/Emphysema				**Sleep Apnea**			
Diabetes				**Thyroid Disease**			
Gout				**Other:**			

SHARE
State Health Alliance for Records Exchange

SHARE Patient Participation

Your health information. Your choice.

Let's face it. Filling out lengthy medical history forms when you see the doctor can be painful enough to keep you from ever going back. Wouldn't it be great if you never had to see another clipboard? And what if you could get better care, spend less money at the doctor's office, and save your own life in an emergency? It's all possible through SHARE (Arkansas State Health Alliance for Records Exchange).

Your health information WILL BE made available to your participating health care providers unless you OPT-OUT. Please read this carefully and decide whether you wish to participate.

Autumn Road Family Practice, 904 Autumn Road, Ste. 200, LR, AR 72211

What is SHARE?

SHARE is a way of sharing your health information statewide among your doctors, hospitals, labs, radiology centers, and other providers through secure, electronic means. By having access to your up-to-date health information, your doctor can provide safer, more effective health care that is tailored to your personal medical needs.

Why should I share my health info in SHARE?

1. **It can improve your care.**
Health care providers need your health information to accurately diagnose and treat you. They can give you better care with access your complete record.

2. **It will save time & money.**
Access to medical tests and results may reduce the tests that are ordered, which can save you money.

3. **It may save your life in an emergency.**
Through SHARE, a provider can get vital medical information to treat you in case of an emergency when you might not be able to answer questions.

Who can access my information?

Participating health care providers can access your information for treatment, coordination of care, and public health reporting. You can view participants at sharearkansas.com. SHARE employees will have access for technical and administrative support.

What health information will be shared?

Lab and X-ray results, diagnoses, drug allergies, prescriptions, immunization history and more will be available in SHARE. Sensitive information *will not* be included, such as adoption and substance abuse treatment records.

How is my privacy protected?

Information exchanged through SHARE is protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). HIPAA regulates the use of your personal health information and requires protection.

Are there privacy risks?

SHARE carefully protects and secures personal health information. However, no system of safeguards is perfect. Those who take part in SHARE believe the benefits outweigh the risks.

Can I hide records I don't want my providers to see?

No. SHARE cannot exclude specific visits, tests or episodes of care, or specific providers. Opting-out means that no one will be able to access your health information through SHARE except in an emergency. If you do not want some or all of your information made available through SHARE, you should consider opting-out.

How can I opt-out of SHARE?

If you wish to opt-out, ask your health care provider. You can also opt-out for your minor child (under age 18) using the same process.

This and other participating entities will not withhold coverage or care if you choose not to exchange your protected health information through SHARE.

If I opt-out, can I change my mind later?

Yes. You can change your mind and revoke the request by telling the healthcare facility and requesting to terminate your previous decision. When you do this, the information participating providers have gathered since you opted-out will be available through SHARE.

☐ I wish to participate in SHARE.

☐ I wish to opt-out of SHARE, except in a Medical Emergency.

PRINT NAME ____________ / DOB ____________ TODAY'S DATE ____________

Signature ____________

Questions: www.sharearkansas.com

AUTUMN ROAD FAMILY PRACTICE

HIPAA AUTHORIZATIONS

Please list other parties who may have access to your health information: ◯ None

Name: ____________________ Relationship: __________ Phone: _______________________________
Name: ____________________ Relationship: __________ Phone: _______________________________
Name: ____________________ Relationship: __________ Phone: _______________________________

Please list any parties whom we may inform of your medical condition **ONLY IN AN EMERGENCY.** ◯ None

Name: ____________________ Relationship: __________ Phone: _______________________________
Name: ____________________ Relationship: __________ Phone: _______________________________
Name: ____________________ Relationship: __________ Phone: _______________________________

Which address would you like your billing statements and/or other correspondence from our office mailed to?
◯ Home ◯ Other: __________________________________
____
____

Which phone number(s) can we call to discuss appointments, lab or imaging results, billing, or other healthcare information? Can we leave a message—which may contain confidential information or appointment information—on those numbers?

◯ Home ◯ A message may be left here ◯ Do not leave a message here
◯ Cell ◯ A message may be left here ◯ Do not leave a message here
◯ Work ◯ A message may be left here ◯ Do not leave a message here
◯ Other: ______________ ◯ A message may be left here ◯ Do not leave a message

I acknowledge receipt of Autumn Road Family Practice's Privacy Notice. Initials ________

Patient Name (Print): ____ Date of Birth: _____/_____/_____

Patient / Guardian Signature: _________________________________ Date: _____ / _____ / _____

This notice will remain in effect until such time as our office is notified in writing by the patient of any changes.

AUTUMN ROAD FAMILY PRACTICE

FINANCIAL POLICY

Thank you for choosing Autumn Road Family Practice (ARFP) as your healthcare provider. We are committed to providing you with the best possible care. We ask you to read and sign this document (at your first visit, annually thereafter or anew whenever the policy is updated) prior to any treatment so that you are informed of our financial, collection and missed appointment policies.

Insurance Terminology	ARFP Information
Your insurance is a contract between you and your insurance company. However, we are pleased to be of service by filing your medical insurance for you.	In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Insurance policies have coverage limitations. ARFP is not responsible for any limitations in coverage that may be included in your plan. If your insurance company has not paid a claim on your behalf within 90 days because of information that you have not provided, the balance will be transferred to your account, and you will be responsible for the payment.
Co-pay is a flat fee that a patient pays every time they receive medical service (for example, $40 for every visit to the doctor).	Applicable co-pays will be collected at every visit before services are rendered as required by insurance carriers.
Covered expenses – Most health insurance plans, whether they are fee-for-service, HMOs, or PPOs do not pay for all health care services. Some may not pay for prescription drugs. Others may not pay for mental health. Covered health care services are those medical procedures the health insurer agrees to pay for. They are listed in your health insurance policy.	Coverage varies on each insurance policy (e.g., a BCBS insurance policy for one person/company may differ from another). Thus, the patient must be familiar with their personalized coverage details as it is not possible for ARFP to know every detail on each person's insurance plan.
Co-insurance is the amount a patient is required to pay for medical care in a fee-for-service health plan after the deductible is met. The co-insurance rate is usually expressed as a percentage. For example, the health insurance company pays 80% of the health claim, the patient pays 20%.	Applicable co-insurance fees will be billed to you by ARFP once your insurance company notifies us of your payment portion.
Coordination of Benefits is a system to eliminate duplication of benefits when a patient is covered under more than one group health insurance plan/medical insurance plan. Benefits under the two health insurance plans usually are limited to no more than 100% of the health plan.	ARFP will file your primary insurance first. Your secondary insurance will be filed, as appropriate, after we receive payment/ non-payment details from your primary insurance carrier.
Deductible is the amount of money the patient must pay each year to cover their medical expenses before their health insurance policy starts paying.	ARFP asks you to pay towards your deductible at the time of service.

<table>
<tr>
<td>Motor Vehicle Accidents (MVA)</td>
<td>In the event you are involved in a motor vehicle accident (MVA), you are expected to pay for services when rendered. We require a $135 deposit for all patients' first and each follow-up visit scheduled as a result of a MVA. We will gladly provide all necessary paperwork needed for you to file your insurance claims with your carrier.</td>
</tr>
<tr>
<td>Self-Pay (1)
Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. It is always the patient's responsibility to know if our office is participating with their plan. Self-pay patients will be required to pay a designated amount at time of service and will be asked to make payment arrangements for the balance.</td>
<td>Self-Pay Patient Visit (WITHOUT a PHYSICAL)

• New Patients: All new self-pay patients are required to pay a Minimum DEPOSIT for a non-physical visit of $150 at the time of service. This is only a deposit. Additional costs may be incurred and billed at a later date depending on the tests the provider orders or the patient requests.
• Established Patients: All established self-pay patients are required to pay a minimum DEPOSIT for a non-physical visit of $115 at the time of service unless prior arrangements have been made with our office. This is only a deposit. More costs may be incurred and billed at a later date depending on tests the provider orders or the patient requests.

Self-Pay Patient Visit (WITH a PHYSICAL)

• A "standardized" physical includes the following labs (CBC, metabolic panel, thyroid, cholesterol screening and urine testing). Any additional labs recommended by the provider and performed; or, performed per patient request will entail an additional cost above the amount of the deposit; and, will be billed separately to the patient's address. (7/19/18)
---- ---- ---- ---- ----
• New Patients: All new self-pay patients are required to pay a minimum DEPOSIT for a visit (WITH a physical) of $270 at the time of service. This is only a DEPOSIT. More costs may be incurred and billed at a later date depending on tests the provider orders or the patient requests. (7/19/18)
• Established Patients: All established self-pay patients are required to pay a minimum DEPOSIT for a visit (WITHOUT a physical) of $240 at the time of service unless prior arrangements have been made with our office. This only a DEPOSIT. More costs may be incurred and billed at a later date depending on tests the provider orders or the patient requests. (7/19/18)
• Department of Transportation Physical (DOT): includes screening exam necessary to obtain DOT driver's license by certified screener and paperwork completion. Cost is $150 and will include UA. Additional labs billed to patient. Follow up visits to complete physical/paperwork will be $35 (these are needed if patient does not have necessary items to complete physical on initial visit).</td>
</tr>
<tr>
<td colspan="2">Form Fees
We charge for the completion of forms, (i.e., FMLA, disability insurance, etc.) as it requires office staff time and time away from patient care. We charge $25 for each different form, each different time.</td>
</tr>
</table>

Missed Appointments and Late Arrivals

Missed Appointments include the following:	Missed Appointment Fees are:
• A scheduled appointment that a patient does not keep (no call/no show). • A scheduled appointment that a patient cancels less than 4 hours before the scheduled appointment time.	• 1st occurrence - $25 charge • 2nd occurrence - $40 charge • 3rd occurrence - $50 charge & patient may be dismissed from the practice Patients who fail to pay the missed appointment fees will not be allowed to schedule future appointments until the fee is paid in full.

Late Arrivals: Patients that arrive 5 minutes beyond their scheduled appointment time may require:

- Rescheduling if the provider's schedule will not accommodate this loss of time.
- Extended waiting if your physician's schedule will accommodate working you in as time allows based on the remaining patients to be seen. Work-ins must be approved by the MD/nursing staff.
- Rescheduling with another MD/APRN who has an open appointment available.

Delinquent Payment / Collection Policies

- We request payment in full for services rendered within 30 days of receiving an initial statement from ARFP.
- An outside collection agency manages all ARFP accounts that remain unpaid after 90 days of receiving an initial statement from ARFP.
- If you wish to speak with our Billing Office about alternate payment options – please let us know.

Payment Options Accepted	Business Office Contact Information
Autumn Road Family Practice accepts the following payment options: Cash / Personal Checks* / Money Orders / Debit Cards Visa / American Express / MasterCard / Discover ***By using a check for payment**, you agree to the following terms: In the event your check is dishonored or returned for any reason, you authorize us to electronically (or by paper draft) re-present the check to your bank account for collection of the amount of the check, plus any applicable fees as permitted by state law.	At Autumn Road Family Practice, we appreciate your business. We welcome you to contact our Business Office if you have a question about your bill; or, wish to speak with a billing representative before you receive service. You can reach our Billing Office, Monday-Friday, 8 am – 4:30 pm. Dial 501-227-6363 and follow the prompts. You may leave a secure voice message after hours and our Business Office staff will return your call the following business day.

Assignment of Insurance Benefits (if applicable) and Acknowledgement of ARFP's Financial Policy

As applicable, I request that payment of insurance benefits be made on my behalf to Autumn Road Family Practice for any services furnished to me by any provider in the clinic. I authorize any holder of medical information about me to release any information needed to determine benefits to my insurance carrier, and where applicable, to the Center of Medicare and Medicaid Services and its agents. I further authorize the clinic and it's agent to verify employment and wage data in the event collection action becomes necessary.

Additionally, I acknowledge notification of ARFP's Financial Policy.

PRINT YOUR NAME:	**DATE OF BIRTH:**
SIGNATURE OF PATIENT or RESPONSIBLE PARTY:	**TODAY'S DATE:**

SIGNATURE OF CO-RESPONSIBLE PARTY:	**TODAY'S DATE:**

For office use **ACCOUNT #**	

(1) When this section is updated, ensure *Patient Scheduling Guidelines* policy wording is congruent.