Paragould DOCTORS CLINIC

4000 Linwood Drive Suite A Paragould, AR 72450
Phone: (870) 239-8503 Fax: (870) 236-1947

Patient Registration (Please Complete ALL Forms)

Date: _____ Account Number:_____

Name: (Last) _____ (First) _____ (Middle) _____

Mailing Address: _____

Physical Address: _____

City: _____ State: ____ ZIP: _____

Birth Date: _____ Soc. Sec. No: _____ Sex: M F

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Contact By: Phone Mail Email

Emergency Contact: (Name) _____ (Phone) _____ (Relationship) _____

Local Pharmacy: _____ Town: _____

Preferred Language: _____ Level of Education: _____

Marital Status: Married Single Widowed

Do you smoke?: No Yes If so, how many packs per day?_____ How many years?_____

Race: White Black Asian Pacific Islander Multi-Racial Hispanic Other: _____

Responsible Party if under 18 yrs of age: Self Spouse Parent Guardian

Name: (Last) _____ (First) _____ (Middle) _____

Address: _____

City: _____ State: ____ ZIP: _____

Birth Date: _____ Soc. Sec. No: _____ Sex: M F

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Contact By: Phone Mail Email

Insurance Information

4000 Linwood Drive Suite A Paragould, AR 72450
Phone: (870) 239-8503 Fax: (870) 236-1947

Primary Insurance: _____

Name of Insured: (Last) _____ **(First)** _____ **(Middle)** _____

Insured Party: **Self** **Spouse** **Parent** **Other** **Insured's Date of Birth:** _____

ID #:_____ **Group #:**_____

Insurance Address: _____

City: _____ **State:** _____ **ZIP:** _____

Secondary Insurance: _____

Name of Insured: (Last) _____ **(First)** _____ **(Middle)** _____

Insured Party: **Self** **Spouse** **Parent** **Other** **Insured's Date of Birth:** _____

ID #:_____ **Group #:**_____

Insurance Address: _____

City: _____ **State:** _____ **ZIP:** _____

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If you have any other insurance policies, please ask the receptionist for an additional form.

Please present your insurance cards to the receptionist.

I authorize the release of all information of any kind that you may have regarding me, including but not limited to, all medical and other records, reports, bill, and other information of any kind. This authorization also specifically authorizes the release of any such information regarding drugs, alcohol, or H.I.V. I authorize the release of medical information necessary to process claims filed on my behalf.

A photocopy of this medical authorization shall be as effective as the original. This authorization is valid for 18 months from the date hereof.

X_____ **X**_____
Patient's/Guardian's Signature **Insured's Signature**

_____
Date

I authorize payment of medical benefits to be made directly to the supplier or provider of services performed. This authorization is valid for 18 months from the date hereof.

X_____ **X**_____
Patient's /Guardian's Signature **Insured's Signature**

_____
Date

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PATIENT HISTORY (Please Complete ALL Forms)

NAME: **DATE:**

DRUG ALLERGIES (Type of Reaction)

CURRENT MEDICATIONS (Name, Dose, Frequency)

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Bleeding Disorder						
Diabetes						
Epilepsy/Convulsions						
Glaucoma						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Lung Disease						
Mental Illness						
Stomach/Colon						
Stroke						
Thyroid Disease						
Cancer Type (important):						
Other:						

PATIENT HISTORY (Please Complete ALL Forms)

NAME:

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PAST MEDICAL HISTORY (Circle all that apply)		
Recent Weight Loss	Heart Attack	Irritable Bowel Syndrome
Migraine Headaches	High Blood Pressure	Constipation
Epilepsy/Convulsions	High Cholesterol	Other Bowel Problems
Eye Disease (Other than glasses)	Congestive Heart Failure	Liver/Hepatitis
Neurological	Stroke	Kidney/Bladder
Hearing Disorder	Heart Valve Disorder	Anemia
Depression	Angina – Chest Pain	Arthritis
Anxiety	Asthma	Autoimmune Disease
ADHD	COPD	Osteoporosis
Other Mental Illness	Other Lung Disease	Blood Transfusion
Recurrent Nose Bleeds	Diabetes	Stomach Ulcer
Recurrent Sinus/Throat Infections	Alcoholism	Bleeding Disorder
		HIV
OTHERS:	CANCER – Type:	

PAST HOSPITALIZATION OR SURGERIES

REASON:	DATE:

IMMUNIZATIONS		HABITS	CANCER SCREENING
NAME	DATE		
Influenza vaccine		Alcohol—Type/Amount:	Colorectal Cancer (e. g. Colonoscopy)
Hepatitis B		Any illegal drugs?:	Date:
Pneumonia			Normal: Yes No
Tetanus			

FOR WOMEN ONLY	
Date of last period:	
Do you use birth control: Yes No	
Type of birth control:	
# of pregnancies:	# of live births:
# of miscarriages:	# of abortions:
Date of last PAP:	Normal: Yes No
Mammogram:	Normal: Yes No

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CONDITIONS OF TREATMENT

1. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I have been informed of my rights to privacy in the use and disclosure of my protected health information as it relates to treatment, payment, or healthcare operations as documented in the notice of privacy. I understand that my protected health information may be released without authorization as needed for treatment, payment, or healthcare operations.

2. GENERAL CONSENT TO TREATMENT AND TESTS: I desire to be treated by Doctors Health Group d/b/a Paragould Doctors'Clinic. I permit my attending and consulting physician and/or nurse practitioner, and their employees and others involved in my care to treat me in the ways they judge to be beneficial to me. I understand that I have a right to ask questions and to receive information about my care and treatment, medical advice. I release the physician(s) and/or nurse practitioner(s) from any liability. I consent to examinations, x-rays, blood tests, laboratory procedures, medications and other medical services or treatments, including photographic documentation, rendered by Doctors Health Group, d/b/a Paragould Doctors'Clinic under the instruction, orders, or directions of such physician(s) and/or nurse practitioner(s). I understand, except in emergency situations, it is the attending physician(s)' responsibility to inform the patient or the patient's representative concerning a proposed treatment, and to obtain the consent of the patient or his representative before proceeding. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge and agree that no guarantees have been made to me as to the results or outcome of my medical care.

3. ASSIGNMENT OF INSURANCE BENEFITS: I certify that the information given to me in applying for payments under Titles XVIII and XIX of the Social Security Act, or under other insurance coverage, is correct. For Title XIX beneficiaries, I understand that I must provide my Medicaid number at the time of treatment; otherwise, I may be billed as a private pay patient. I request that payment of authorized benefits be made on my behalf to Doctors Health Group d/b/a Paragould Doctors'Clinic. I understand that I am fully responsible to Doctors Health Group d/b/a Paragould Doctors' Clinic and other provider charges and all regular and customary fees. The assignment of benefits does not relieve me of my personal responsibility to pay the fees and charges when due. I hold Doctors Health Group d/b/a Paragould Doctors'Clinic harmless of any reduction in healthcare benefits by my insurance company resulting from non-compliance with any clause or condition contained in my policy which may require: Notification; Pre-Certification; Prior to Retrospective Authorization, or Utilization Review of the medical service I receive. Assignment of insurance benefits is valid and binding until final settlement of the account is received.

4. FINANCIAL AGREEMENT: The undersigned, whether he/she is the patient or is signing as the patient's authorized representative, hereby agrees that the patient and/or Guarantor shall be responsible for any and all services rendered by any and all providers pursuant to this admission. The undersigned, whether he/she is the patient or is signing as the patient's authorized representative, hereby further agrees that the patient shall be personally responsible for any and all charges deemed un-reimbursable by the Guarantor.

The above conditions apply to services rendered by Doctors Health Group d/b/a Paragould Doctors'Clinic. Assignment of insurance benefits is valid and binding until final settlement of the account is received. The undersigned certifies that he/she has read or has been read this form, has received a copy, is the patient or patient's authorized representative, and fully understands and accepts these conditions of admission. If the undersigned is signing as the patient's authorized representative, he/she certifies that the patient is not personally able to sign. The undersigned further certifies and warrants that he/she is signing on behalf of the patient and at the express direction of the patient.

The undersigned bears the relationship of _____ to the patient.

X_____ _____

Patient's Signature Date and Time of Signing

X_____ _____

Patient's spouse, Representative, Agent, or Guarantor Signature DHG d/b/a Paragould Doctors' Clinic Employee Signature

Doctors Health Group d/b/a Paragould Doctors Clinic
Consent to Treatment

Doctors Health Group Inc. d/b/a Paragould Doctors Clinic
Consent to Treatment

A. Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment.

Medicare: I request payment of authorized Medicare benefits on my behalf for any services furnished to me by Doctors Health Group d/b/a Paragould Doctors Clinic. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

B. Insured's or Authorized Person's Signature: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

C. Consent To Treatment And Tests: I consent to examinations, x-rays, blood tests, laboratory procedures, medications, and other medical services or treatments including photographic documentation, rendered by Doctors Health Group d/b/a Paragould Doctors Clinic under the instruction, orders, or directions of physician(s) and/or nurse practitioner(s). I understand that my protected health information may be released without authorization as needed for treatment, payment, or health care operations.

D. I consent to my insurance drug formulary and my medication history being checked electronically.

E. I agree that the facility, Paragould Doctors' Clinic, or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or is otherwise associated with my account.

Please answer the following questions:

If you are a Medicare patient and the answer to any of the questions below is "yes," please proceed no further and fill out the detailed Medicare Secondary Payer Questionnaire.

1. Are you receiving Black Lung benefits: Yes _____ No _____
2. Is today's visit due to a work-related accident? Yes _____ No _____
3. Is today's visit due to a non-work-related accident? Yes _____ No _____
4. Are you or your spouse currently employed? Yes _____ No _____
5. Do you have group health plan coverage? Yes _____ No _____
6. Do you qualify for Medicare due to End-Stage Renal Disease? Yes _____ No _____

Patient Signature: _____ Date:

Guarantor Signature: _____ Date:

If other than guarantor, relationship to patient: _____

PARAGOULD DOCTORS' CLINIC

4000 Linwood Drive, Suite A – Paragould, AR 72450

AUTHORIZATION TO ACCESS HEALTH INFORMATION

NAME: _____ **SSN#:** _____ **DOB:** _____

ADDRESS: _____

Pursuant to Federal Guidelines concerning my right to confidentiality

1. **PARTY TO RECEIVE INFORMATION:**

I hereby authorize: _____
Entity, person(s), or class of persons

To release to: _____
Entity, person(s), or class of persons

2. **TYPES OF INFORMATION:**

The type and amount of information to be used or disclosed is as follows:

□ Entire medical record for _____
Date(s) of service

OR

□ History/physical	□ Progress notes	□ Itemized statement
□ Discharge summary	□ Nurses notes	□ Other (Please specify)
□ Consultation report	□ Medication records	_____
□ Operative report	□ Laboratory results	
□ Physician's orders	□ X−ray results	_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. **METHOD OF RECORD RELEASE:**

□ Paper copy via mail: _____
Mailing address

□ Paper copy to be picked up in person

□ Encrypted electronic copy via email: _____
Email address

□ Other (via password-protected cd) : _____
Describe above

4. **FOR THE PURPOSE OF:** _____
Describe above

5. **REVOCATION AND EXPIRATION:**

This authorization may be revoked at any time by my written consent except to the extent that action has already been taken in reliance thereon. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Privacy Officer (225 E. Jackson Street, Jonesboro, AR 72401; (870) 207.4422). I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in 6 months.

6. **FAILURE TO SIGN AUTHORIZATION:**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re−disclosure and the information may not be protected by federal confidentiality rules. If I have questions of my health information, I can contact the Privacy Officer at the above address and telephone number.

7. **Paragould Doctors Clinic may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization.**

8. **Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected under federal privacy law.**

_____ _____
Signature of Patient or Personal Representative Date/Time

_____ _____
If signed by Personal Representative, Relationship to Patient SIgnature of Witness