THRONEBERRY FAMILY CLINIC

PATIENT INFORMATION

Acct #_____

PATIENT INFORMATION

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

Address:_____ City:_____ ST:_____ Zip_____

Social Security #:_____ - ____-_____ Birthdate:_____

Cell phone #:_____ **Home or Message#:**_____ Name_____
(Please list an extra number to reach you other than Emergency contact)

Sex: M or F Marital Status : M S D W Ethnicity: Hispanic [ ] Not Hispanic [ ]

Race : White [ ] African American [ ] Native American [ ] Asian [ ] Other [ ]

Employer:_____ **Work phone #:**_____

Emergency Contact:_____ Relationship:_____

Emergency Contact Ph. #: _____ Email:_____

Pharmacy:_____

SPOUSE'S INFORMATION

Name:_____ **Cell Phone #:**_____

Birthdate:_____ SSN# _____-___-_____

Employer:_____ **Employer Ph#:**_____

GUARANTOR INFORMATION (Person responsible for the bill)

If self and contact information is same as above, just check here [ ]

Relationship of Guarantor to Patient: Parent _____ Guardian _____ Other_____

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

Address:_____ City:_____ ST:_____ Zip:_____

Birthdate:_____ SSN: _____ Sex: M or F

Home Ph #:_____ Cell Ph #:_____

INSURANCE INFORMATION

Primary Ins:_____

Effective Date:_____

Policy Holder's Name:_____

D.O.B.:_____ SSN#: ____-___-____
(Policy holder's) (Policy holder's)

Policy/ID #:_____

Group #:_____

Secondary Ins:_____

Effective Date:_____

Policy Holder's Name:_____

D.O.B.:_____ SSN#: ____-____-____
(Policy holder's) (Policy Holder's)

Policy/ID #:_____

Group #_____

Please list any **immediate** family members name and their relationship to you that are current patients here:

_____ _____ _____

_____ _____

SIGNATURE DATE

Throneberry Family Clinic
2869 College Ave.
Conway, AR 72034

Comprehensive Patient History Form **Date**_____

Patient Name:_____ DOB:_____
Are you allergic to any Medications? _____ If so, please list:_____

List previous hospitalizations/surgeries/serious injuries When:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Have you ever had the following?

Diabetes.....yes no
Hypertension.....yes no
Cancer.....yes no
Stroke.....yes no
Heart trouble.....yes no
Arthritis/gout.....yes no
Convulsions.....yes no
Bleeding tendency.....yes no
Acute infections.....yes no
Venereal disease.....yes no
Hereditary defects...yes no
Other medical not listed..yes no
If Yes, _____

Patient Social History

Marital Status : Single__ Married__ Separated__ Divorced__ Widowed_____
Use of alcohol: Never__ Rarely__ Moderate__ Daily__ , amount_____
Use of tobacco: Never__ Previously but quit__ Current__ , packs per day_____
Use of drugs: Never__ Type/Frequency_____
Excessive exposure at home or work to: Fumes___Dust___Solvents___ Noise___
Employment History (What type of work?)_____

List Medications you are currently taking & dosage:

1)_____
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____
8)_____

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Patient Signature _____

THRONEBERRY FAMILY CLINIC

FINANCIAL AND APPOINTMENT POLICY

All patients with or without insurance are required to pay at the time of service. If I do not have my insurance card, I understand that I may be asked to reschedule. We will accept Cash, Mastercard, Visa, or Pre-Approved personal Checks. If you have a copay, this will be collected at the front window. All other deductible/coins that is your responsibility will be collected when you check out. We will calculate these charges to the best of our ability, but after filing your claim with the insurance company if there is a balance due, we will send you a statement or collect at your next visit. If there is a refund due, we will either refund you or apply it to your account.

I hereby authorize the release of any medical information related to claims for benefits submitted on behalf of myself or my dependents. I authorize all my rights, title and interest to my medical reimbursement benefits under my insurance policy to Throneberry Family Clinic for services rendered. I understand this authorization shall remain valid until written notice is given by my revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by my insurance.

I agree it is my responsibility to know and understand my insurance policy regarding referrals, hospital and test pre-certifications, deductible, coinsurance and copayments. It is the policy of Throneberry Family Clinic to help the patient in obtaining full benefits from your insurance company. However, it is the patient responsibility providing the insurance company with all information requested in a prompt manner.

Our appointment policy is as follows. We will confirm appointments a day in advance by calling the contact number given us. This is done as a courtesy to you. Cancelling or rescheduling of appointments is your responsibility. We have the right to charge for missed appointments as we deem necessary. This fee is not covered by your insurance company, it would need paid before another appointment can be made.

If you have any questions concerning these policies, please call the office and ask to speak to the Office Manager.

I acknowledge that I have read and understand the policies stated above.

Patient Name:_____

Signature(parent if minor):_____ Date:_____

THRONEBERRY FAMILY 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.

This Notice provides you with information on the steps this Clinic has taken to protect the privacy of your Protected Health Information. It also describes some of the privacy rights you have and how you can exercise those rights. Please read this carefully. If you have any questions, please ask the receptionist if you can speak with Lisa Hust at 327-2611, who is our Privacy Official. Our Privacy Official can answer any questions you may have concerning this Notice.
Your Protected Health Information is that information that is created or received by this Clinic, transmitted by electronic form or maintained in any medium, that identifies you or could reasonably identify you, and relates to your past, present, or future;

1) Physical or mental health or condition;
2) Your health care treatment; or
3) The payment of your health care services.

I. USES AND DISCLOSURES :

A. The following are examples of some of the ways the Clinic may use and disclose your Protected Health Information (PHI) Based on your signing our Clinic's consent form:

1) Treatment - In order to adequately provide for your health care needs, your PHI will be used and disclosed within the Clinic, by the Clinic employees, and independent contractors as necessary to treat, evaluate, and provide you with health care services. This may also include the need for us to obtain PHI from your previous health care providers in order for us to treat you properly.

2) Payment – To receive payment for our services, the Clinic will have to disclose certain PHI to your Health Plan or Insurer. This could require disclosure prior to treatment to obtain pre-certification from your Insurer to perform a procedure or it could be a post treatment disclosure to obtain payment for the services provided. Your Insurer also has a right to demand access to your records to determine eligibility for making pre-existing condition determinations or for conducting quality control inspections. PHI may also be disclosed to comply with workers compensation laws and similar programs. The Clinic may also use and disclose limited PHI to consumer reporting agencies relating to collection of payments owed to the Clinic.

3) Clinic Operations – To ensure the proper functioning of our clinic, it may be necessary form time to time that certain PHI be used and disclosed. For example, we may use a sign in sheet at the front desk to keep track of which patients have arrived. We may call out your name when it is time for you to come back to an exam room. Our employees and independent contractors may have to access your medical records for certain business operations. Our clinic may allow high school, college, or medical school "shadow" students in the clinic and they may be exposed to certain PHI.

4) Referrals – In order to effectively refer you to another physician, we will have to release certain PHI to that physician to assist the physician in your treatment and to make the necessary appointment.

5) Consultations – There may be occasions where the Clinic may desire to consult another professional about your treatment to get a second opinion. In those situations, the Clinic will always attempt to maintain your privacy to the extent possible, recognizing that it may not always be an option.

6) Business Associates – As part of our business operations we have to enter into agreements with third parties to assist us. These third parties can be accountants, computer consultants, transcriptionists, etc. These third parties may have to access certain PHI. Prior to any of our Business Associates having access to PHI, they will sign an agreement that requires them to have procedures in place to protect the privacy of your PHI.

B. The following are examples of some of the ways the clinic may use and disclose your Protected Health Information (PHI) based on your opportunity to orally assent or object:

1) Family Members of Individuals Involved in Your Care – This clinic may use and disclose PHI to your family members or other individuals who are involved in your care when the clinic believes it is necessary to proved your location, general health condition, and in the case of your death. An example might be if you needed a ride home, we might contact a relative and provide you a ride. You may inform our Privacy Official in writing if you choose to object to this use or disclosure.
2) Faculty Directories – We may use PHI to maintain a listing of the name, location, general condition, and religious affiliation of individuals in our facilities and disclose it to religious personnel and to others who specifically request the information by identifying the individual by name. You may inform our Privacy Official in writing if you choose to object to this use or disclosure.

3) Release of Immunization Records To Schools – The Clinic may release immunization records directly to schools with only an oral authorization from a parent or person acting in the place of a parent.

C. The following are examples of some of the ways the Clinic may use and disclose your Protected Health Information (PHI) without your consent, authorization, or opportunity to assent or object:

1) Legal Obligations – This Clinic will use and disclose PHI when legally required. If this situation occurs, we will notify you and we will limit the PHI to the minimum necessary to comply with the law. Some examples are as follows: court orders, subpoenas, reporting suspected abuse or neglect, reporting adverse results to the Food and Drug Administration, reporting exposures to communicable diseases, certain criminal activity, and military activity.
2) Inmates – If you are an inmate, this Clinic may use or disclose PHI to the facility and correctional officers when appropriate.
3) Emergencies – In an emergency treatment situation, our Clinic may use or disclose PHI. Our Clinic's health care professional will obtain your consent as soon as practicable following the emergency.
4) Communication Barrier – If there is a substantial communication barrier, this Clinic may use or disclose PHI for treatment, payment, or health care operations when circumstances would infer consent.

D. The following are examples of some of the ways the Clinic may use and disclose your Protected Health Information (PHI) based on your signing our Clinic's Authorization form-

Other uses and disclosures of your PHI that do not fit into one of the above categories shall only be allowed upon your signing one of our clinic's specific authorization forms. An example of when this may be necessary is if you would want our Clinic to release your medical records to your employer. You would need to come in and complete a specific authorization for us to disclose your PHI to your employer, unless of course your employer is your health insurer. If your employer is your private health insurer, then it would have access to your medical records through your consent. You have the right to revoke any authorization, however, the revocation will not be effective to the extent the clinic has relied on it.

E. Certain disclosures cannot be made without your specific authorization.

1) Psychotherapy notes. Most uses and disclosures of psychotherapy notes are prohibited unless you specifically authorize their release.
2) Sale of PHI. The sale of PHI occurs when the Clinic makes a disclosure of PHI and directly or in directly receives remuneration from the recipient in exchange for the PHI.
3) Use of PHI for Marketing. The Clinic may use PHI for marketing purposes.

F. Additional disclosures include:

1) Use of PHI for Fundraising. PHI may be used for fundraising purposes. You have the right to opt out of receiving such communications by contacting the Privacy Official, Lisa Hust.
2) Disclosure of PHI to a Plan Sponsor. PHI may be disclosed to a plan sponsor, in cases of a group health plan, health insurance, or HMO.
3) Disclosure of PHI for Underwriting Purposes. PHI may be disclosed for underwriting purposes, in which case PHI that is genetic information will be excluded from such disclosure.

II. RIGHTS:

A. Right to request a Restriction of Uses and Disclosures - You have the right to notify our Privacy Official in writing that you request a restriction on our use and disclosure of your PHI. Our Clinic does not have to grant your request and we can condition treatment on your willingness to consent to our uses and disclosures of your PHI. We will notify you in writing whether we will grant or deny your request. If your request is granted, we may choose, at a later date, to deny to continue the restriction and if so, we will notify you in writing of that decision.

B. Right to Request Confidential Communications - You have the right, by making a written request, to request that all our communication with you concerning your PHI be confidential. Your request must tell us how or where you wish to be contacted. We are required to accommodate only reasonable requests. We cannot ask you the reason for such a request.

C. Right to Inspect and Copy – You have the right, by making a written request, to inspect and copy your PHI. There are a few exceptions to this rule. We must approve or deny your request within 30 days, although a onetime 30 day extension is allowed. In the case of a denial, we will provide you with an explanation for the denial. We will charge a reasonable fee for copying, preparation, and postage (if mailed to you) which must be prepaid. If the Clinic has electronic medical records, you also have the right to request that your PHI be provided to you in an electronic format.

D. Right to Amend – You have the right, by making a written request, to request that we amend your PHI that we created. If you make such a written request, we will act on your request and respond in writing within 60 days. Should your request be denied, an explanation will be provided. You will have the right to appeal any denial to amend PHI

E. Right to Receive and Accounting – You have the right, by making a written request, to request that we provide you with an accounting of our disclosure of your PHI. The accounting will be provided within 60 days of the request. Standard disclosures a are not included in the accounting. Examples of standard disclosures would be disclosures to you, for treatment, payment, and health care operations. The first accounting in a 12 month period is free. Any subsequent request for an accounting in the same 12 month period will result in a reasonable, cost-based fee.

F. Right to Receive Copy of Notice – You have a right to receive a paper copy of our Notice of Privacy Practices. You may pick one up in our waiting room.

G. Right to File a Complaint – The law requires us to comply with HIPAA and our Notice of Privacy Practices. If you feel we are not in compliance, you have the right to file an anonymous complaint with our office. We have an anonymous drop box in our waiting room. You also can file a complaint by notifying our Privacy official in writing. We will not retaliate in any manner due to a complaint. We value your opinion. You also have a right to file a complaint with the Secretary of the Dept of Health and Human Services, who is charged with enforcement of this regulation.

H. Right to Restrict Release of PHI for Certain Services – You have the right to restrict the disclosure of information regarding services, treatment or other items for which you have paid in full or on an out of pocket basis. This information can be released only upon your written authorization.

I. Right to Be Notified in Case of a Breach of PHI – You have the right to be notified of any breach of your unsecured PHI.

III. DISCLOSURE STATEMENTS

A. This Clinic intends to use and disclose PHI in the additional following ways, on which treatment is conditioned: 1) To have you sign in on a sign in sheet 2) To allow our staff to call out your name when it is time for you to come back for an exam, treatment, or consultation; 3) To send our reminders of appointments 4) To provide alternative treatment information 5) To leave messages on voice mail systems with appointment reminder, and 6) To contact you at the phone numbers you provide and leave messages to reschedule appointments or to leave lab results.

B. The Law requires this Clinic have privacy protections for PHI and to give you Notice of its legal responsibilities to individuals.

C. This Clinic has to follow the terms and conditions contained in it Notice of Privacy Practices.

D. The Clinic retains the right to make retroactive changes to its notice of Privacy practices. This means that if the clinic changes its Notice of Privacy Practices and thus changes it Privacy practices and Procedures in can and will apply those changes to PHI it received, obtained, and created prior to those changes if it chooses and states so in the Notice.

E. Any individual who would like a copy of any revised Notices of Private Practices shall submit such a request in writing to the Privacy Official who is Lisa Hust.

F. This Notice if effective this the 9th day of March, 2012.

_____ _____

Patient Date

_____ _____

Personal Representative (if under 18) Date

HIPAA GENERAL CONSENT

I hereby give my consent for Throneberry Family Clinic to use or disclose my Protected Health Information to carry out treatment, payment, or any other health care operations. I understand that my Protected Health Information is as follows:

Information that is oral or recorded in any form that relates to my past, present, or future, physical or mental health condition, my past, present, or future health care treatment, or the payment of my past, present, or future health care treatment, that is or could reasonably identify me and is transmitted in an electronic form or maintained in any form.

This Protected Health Information could include information that this Health Care Provider created, received from me, received from another Health Care Provider, received from a Health Plan, Health Care Clearing House, Insurance Company, Employer, or any other source, and could include demographic information about me.

I have been informed that my Health Care Provider has adopted a complete statement of its privacy practices, which are contained in Throneberry Family Clinic Notice of Privacy Practices. I have received a copy of the Notice of Privacy Practices and have had an opportunity to review them and ask any questions concerning them before signing this HIPAA Consent. I understand that my Health Care Provider has the right to change them at any time without advance notice to me. I can request a copy of my Health Care Provider's latest Notice of Privacy Practices by calling the office, stopping by and picking up a copy, stopping by and reading the Notice that is posted in my Health Care Provider's waiting room, or asking that my name be put on a list to be mailed a copy of any updated Notice of Privacy Practices should my Health Care Provide make changes to the Notice of Privacy Practices.

I understand that I have the right to not give this consent, however, I also understand that my Health Care Provider does not have to treat me if I do not sign this consent.

I understand that I have the right to request restrictions on this consent and to request limits on when and how my Health Care Provider uses and discloses my Protected Health Information, however, I understand my Health Care Provider is not obligated to agree to the restrictions or limitations I request.

I understand that if my Health Care Provider agrees to a restriction, my Health Care Provider shall be bound by the restriction until I release my Health Care Provider from that restriction.

I understand that I have the right to revoke my consent, however, it shall not be considered revoked to the extent my Health Care Provider has relied on it.

I hereby consent to all the uses and disclosures in my Health Care Provider's Notice of Privacy Practices.

_____ _____

Patient – Printed Name Patient – Signature

_____

Date

_____

Personal Representative of Patient

SPECIFIC AUTHORIZATION

I hereby give my authorization for Throneberry Family Clinic to use or disclose my Protected Health Information to carry out treatment, payment, or any other health care operations.

I understand that my Protected Health Information is as follows:

> *Information that is oral or recorded in any form that relates to my past, present, or future, physical or mental health condition, my past, present, or future health care treatment, or the payment of my past, present, or future health care treatment, that is or could reasonably identify me and is transmitted in an electronic form or maintained in any form.*

This Protected Health Information could include information that this Health Care Provider created, received from me, received from another Health Care Provider, received from a Health Plan, Health Care Clearing House, Insurance Company, Employer, or any other source, and could include demographic information about me.

I specifically give this Health Care Provider authorization to use or disclose my Protected Health Information to the following persons for the following purposes:

NAME	RELATIONSHIP	PHONE NUMBER

I understand that I have the right to revoke my authorization; however, it shall not be considered revoked to the extent my Health Care Provider has relied on it. I understand that once this information has been disclosed to third parties, there may not be any safeguards to prevent the third party from further disclosing the Protected Health Information.

I request this authorization expire on the following date: _____. I may revoke it sooner in writing by contacting the Privacy Official Lisa Hust, I may also reach him/her by phone at 501-327-2611. I understand the Health Care Provider can condition my treatment or evaluation on my signing this authorization.

_____ _____

Patient – Printed Name Patient – Signature

_____

Date

_____

Personal Representative of Patient