hope medical clinic

Patient's Name: _____ Date of Birth: _____

Social Security Number: _____ Gender: ☐ Male ☐ Female

Race: ☐ Asian ☐ Black ☐ American Indian/Alaska Native ☐ White ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Island

Preferred language: _____

Mailing Address: _____ City: _____ St: ___ Zip: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Email Address: _____ Preferred Method of Contact: _____

Employer: _____ Marital Status: ☐ Married ☐ Single

Name of Spouse: _____ Spouse's Social Security #: _____

Other Emergency Contact Name: _____

Phone: ( ) _____ Contact's Relationship to You: _____

WE **MUST HAVE ALL** OF THE FOLLOWING INFORMATION AND A COPY OF YOUR INSURANCE CARDS IN ORDER TO FILE YOUR INSURANCE CLAIM FOR YOU.

Primary Insurance Company: _____

Policy Holder's Name: _____ Relationship to You: _____

Policy #: _____ Group #: _____

Policy Holder's Social Security #; _____ Policy Holder's Date of Birth: _____

Do you have a Secondary Insurance Company? ☐ yes ☐ no

If Yes, What is the Company's Name: _____

Policy Holder's Name: _____

- I hereby give consent and authorization for medical treatment by the providers of Hope Medical Clinic.
- I understand I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits. I authorize payment of medical benefits for professional services rendered to Hope Medical Clinic.
- I am aware that all co-pays and deductibles **must** be paid at the time of services. Legally, co-pays and deductibles cannot be waived.
- **NO SHOW POLICY**: I am aware that after the 2nd time I do not keep my appointment or do not cancel 24 hrs prior to my scheduled visit, I may be terminated from Hope Medical Clinic.
- RELEASE OF INFORMATION: I authorize the release of any medical information necessary to process my claim. In addition, I also authorize Hope Medical Clinic to obtain and/or release medical records/information from any other physicians, when necessary, in order to better facilitate my care.
- COLLECTION POLICY / FEES: I understand that if my account is past due and payment has not been received, then my account will be referred to a collection agency. I understand if my account is sent to a collection agency, I will be responsible for a collection fee of 35% which will be added to the principal balance owed. I understand that any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collection agency fees, court costs,interest, and fines. I understand that these additional fees will be my personal responsibility to pay in full.
- RETURN CHECK POLICY: I am aware that if I have a returned check then I will no longer able to pay with a check for any future visits or services, and that I will have to pay my balance in full prior to be being seen again at Hope Medical Clinic.
- AUTOMOBILE ACCIDENTS: In the case of an automobile accident, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If this information is not provided, you will be asked to reschedule your appointment. Patient will be responsible to pay for visit at the time of service. Billing department will provide claim form, receipt, and medical records so patient can receive reimbursement from automobile insurance or their lawyer.

☐ I hereby give consent and authorization to the providers of Hope Medical Clinic to access my medication history.

Signed: _____ Date: _____

hope medical clinic

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received a copy of Hope Medical Clinic's Notice of Privacy Practices.

This Consent was signed by:

Printed Name of Patient or Legal Representative		Printed Name of Practice Representative	
Signature	Date	Signature	Date
Relationship to Patient (if other than patient)			

Hope Medical Clinic - 145 Shake Rag Road, Clinton, AR 72031
(501) 858-4488 - Toll Free (888) 753-3190 - Fax: (501) 745-8714

hope medical clinic

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security Number: _____ Phone: _____

Receive Records From: or Send Records to:

_____ Hope Medical Clinic

_____ PO Box 1333 or 145 Shake Rag Rd.

_____ Clinton, AR. 72031

Phone: _____ Phone: 501-858-4488

Fax: _____ Fax: 501-745-8714

I do authorize this information to be faxed to Hope Medical Clinic. If the file is too large to fax, it may be mailed to the above address.

This information is being disclosed for the purpose of Continuing Health Care.

Complete Health Records to be disclosed or as designated.

☐ All Records ☐ Specific Records: _____

I understand that specific information to be released may include AIDS or HIV, Alcohol and/or Drug Abuse, and Mental Health.

I understand that, if I request copies of records for myself, or a member of my family, a review of this information with my healthcare provider is encouraged. I understand that if the healthcare provider does not feel it is in my best interest, I may designate another healthcare provider to receive these records. I accept responsibility for these copies and information contained herein.

The provider and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I have a right to withdraw this authorization at any time. Request to withdraw must be made in writing andpresented to Practice. I understand that stopping this release will not apply to information that has already been released.

This authorization will expire _____ (insert date or event). If I fail to specify an expiration date or event, this authorization will expire 1 year from the date it was signed.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.

Once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by the federal privacy laws or regulations.

I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used or disclosed under this authorization.

Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.

_____	_____	_____
Signature of Patient or Legal Representative	Relationship to Patient	Date
_____	_____	_____
Signature of Witness	Position	Date

FOR OFFICE USE ONLY: [ ] Verified ID (ex. copy of driver's license, check signature, etc.)
[ ] Picked Up (who) _____ [ ] Mailed [ ] Faxed [ ] Other_____
Office Personnel: _____ Date: _____

hope medical clinic

AUTHORIZATION FOR CALL BACKS

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.*

I understand that under the Health Insurance Portability & Accountability Act of 1996 "HIPAA" I have certain rights to privacy regarding my protected health information.

I specifically give this Health Care Provider authorization to use a particular phone number to leave a detailed message pertaining to lab results and referring appointment information.

☐ Home: _____ ☐ Cell: _____

☐ Other: _____ ☐ No, I do not want to be left messages containing personal information

Please list any persons, other than your doctor, with whom we may discuss your private health information or financial matters.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Patient - Printed Name Date

_____ _____

Patient/Legal Guardian - Signature Relationship to Patient

This form expires on _____ or ☐ never

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SOCIAL HISTORY

Name: _____ Date: _____

Dietary Intolerance: _____ Exercise Habits: _____

Number of Children: _____ Hobbies: _____ Occupation: _____

Do you live: Alone ☐ with Spouse ☐ with Family ☐ Other ☐ State/Country of Birth: _____

Please indicate TOBACCO USE: ☐ No ☐ Yes ___ packs per day ___ years of use Quit Date:_____

Please indicate ALCOHOL USE: ☐ No ☐ Yes _____ number of drinks per week Quit Date:_____

CURRENT MEDICATIONS

Patient Name: _____ Date of Birth: _____

Allergies, Include reaction type: _____ Today's Date: _____

Have You Ever Had a Reaction From Anesthesia? ☐ YES ☐ NO

If yes Explain: _____

Have You Ever Had a Reaction From Latex? ☐ YES ☐ NO

If yes Explain: _____

LIST MEDICATIONS AND DOSAGE

MEDICATION NAME (Include Vitamins and OTC drugs)	DOSAGE	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

PAST MEDICAL HISTORY: Check all that Apply to Your Past and Present Medical History

LIVER
- ☐ Hemochromatosis
- ☐ Cirrhosis
- ☐ Hep A
- ☐ Hep B
- ☐ Hep C
- ☐ Jaundice
- ☐ Fatty Liver

HEART
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Angina
- ☐ Congestive Heart Failure
- ☐ Premature Heart Failure
- ☐ Palpitations
- ☐ Mitral Valve Prolapse
- ☐ Elevated Triglycerides
- ☐ Elevated Cholesterol
- ☐ Rheumatic Fever
- ☐ Heart Valve Disease
- ☐ Endocarditis

BLOOD
- ☐ VonWillebrands'
- ☐ Hemophilia
- ☐ Bleeding or clotting abnormalities
- ☐ History of Blood or Blood product
- ☐ Transfusion

INTEGUMENTARY
- ☐ Eczema
- ☐ Skin Cancer
- ☐ Melanoma
- ☐ Psoriasis

CANCER
- ☐ Colon Cancer
- ☐ Esophageal Cancer
- ☐ Stomach Cancer
- ☐ Breast Cancer
- ☐ Pancreatic Cancer
- ☐ Endometrial Cancer
- ☐ Barrett's Esophagus
- ☐ Liver Cancer
- ☐ Leukemia
- ☐ Lymphoma

RENAL
- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Dialysis

MUSCULOSKELETAL
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Reynaud's
- ☐ Lupus
- ☐ Sjogrens
- ☐ Scleroderma
- ☐ Gout
- ☐ History of Bone Fractures
  Specify site: _____

PSYCHOLOGICAL
- ☐ Bipolar
- ☐ Anxiety
- ☐ Depression
- ☐ Obsessive Compulsive Disorder
- ☐ Schizophrenia

NEUROLOGICAL
- ☐ Stroke
- ☐ Seizures
- ☐ Migraines
- ☐ Other Headache

RESPIRATORY
- ☐ COPD (emphysema)
- ☐ Asthma
- ☐ Tuberculosis (TB)
- ☐ Sleep Apnea
- ☐ Collapsed Lung

GASTROENTESTINAL
- ☐ IBS (Irritable Bowel Syndrome)
- ☐ Diverticulitis
- ☐ Diverticulosis
- ☐ Peptic Ulcer Disease
- ☐ Angiodysplasia of GI tract
- ☐ Gallstones
- ☐ Hoarseness
- ☐ Reflux Esophagitis
- ☐ IBD-Crohn's
- ☐ IBD-Ulcertive Colitis
- ☐ Pancreatits
- ☐ History of GI bleed

ENDOCRINOLOGY
- ☐ Diabetes, type I (insulin needed)
- ☐ Diabetes, Type II (pills needed)
- ☐ Thyroid Disease
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Osteoporosis

SURGICAL PROCEDURES/HOSPITALIZATIONS:

GASTROENTESTINAL
- ☐ Appendectomy
- ☐ Hiatal Hernia Repair
- ☐ Gallbladder Removal
- ☐ Exploratory Surgery for Intestinal Adhesions
- ☐ Gastric Bypass
- ☐ Colon Resection, Partial
- ☐ Gastric Resection, Complete
- ☐ Splenectomy (removal of spleen)
- ☐ Ventral Hernia
- ☐ Incisional Hernia
- ☐ Colonoscopy
- ☐ Upper Endoscopy
- ☐ ERCP
- ☐ Whipple

GYNECOLOGICAL
- ☐ Vaginal Hysterectomy
- ☐ Abdominal Hysterectomy
- ☐ Ovary Removal
- ☐ C-Section
- ☐ Breast Biopsy
- ☐ Mastectomy

GENITOURINARY
- ☐ TURP
- ☐ Bladder Surgery
- ☐ Inguinal Hernia
- ☐ Cystectomy with Ileal conduit
- ☐ Kidney Removal
- ☐ Prostate Removal
- ☐ Radiation for Prostate Cancer

CARDIAC
- ☐ Heart Stent placed
- ☐ CABG
- ☐ Abdominal Aneurysm repair
- ☐ FemPop Bypass (Leg Arteries)
- ☐ Heart Valve replacement
- ☐ Pacemaker (Please present cards)
- ☐ Difibulator (Please present cards)

OTHER
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Glaucoma Surgery
- ☐ Cataract Surgery
- ☐ Laser Surgery

ORTHOPEDIC
- ☐ Artificial Joints

Which joint and when? _____

FAMILY MEDICAL HISTORY Check all that Apply & Indicate Immediate Family Member Affected.

☐ Anemia	☐ Breast Cancer	☐ Cirrhosis of Liver	☐ Colon Polyps	☐ Colorectal Cancer
☐ Crohn's Disease	☐ Diabetes, NIDDM	☐ Diabetes, Insulin Dependant	☐ Gastric Cancer	☐ Gallstones
☐ Heart Disease	☐ Hemochromatosis	☐ Irritable Bowel Syndrome	☐ Liver Disease	☐ Gynecological Cancer
☐ Pancreatic Cancer	☐ Acute Pancreatitis	☐ Chronic Pancreatitis	☐ Peptic Ulcer Disease	☐ Ulcerative Colitis