Ozark Internal Medicine and Pediatrics
Patient Information Sheet

Name:_____ Maiden Name:_____
Date of Birth: _____/_____/_____ Age: _____ Social Security #: _____
Marital Status (please circle): Single Married Divorced Widowed
Race (please circle): white Asian African/American Indian other_____
Address: _____
City, St., Zip: _____ Home Phone #:_____
Cell Phone #: _____ Alternate Phone #: _____
Email: _____
Preferred Method of Communication (please circle): Phone Patient-Portal
Please note: Patient portal is the Clinic's primary method of communication additional wait times will apply for phone calls.
Initial If correct_____

Employer Information:

Employer: _____
Employer Address: _____ City_____ State_____ Zip_____
Employer Phone #: _____ **Initial if correct_____**

Insurance Information:

Member/Policy ID:_____ Group #: _____
Policy Holder: _____
Policy Holder DOB:_____
Policy Holder SS #:_____
Policy Holder Employer: _____ **Initial if correct_____**

Secondary Insurance:

Member/Policy ID:_____ Group #: _____
Policy Holder: _____
Policy Holder DOB:_____
Policy Holder SS #:_____
Policy Holder Employer: _____ **Initial if correct_____**

Pharmacy: _____
Pharmacy Phone #: _____ **initial if correct _____**

Emergency Contact: _____
Emergency Contact#: _____ **initial if correct _____**

Signature: _____ Date: _____

Ozark Internal Medicine and Pediatrics
Notice of Practice Policies

Financial Policy:

Thank you for choosing Ozark Internal Medicine & Pediatrics as your care provider. We are committed to providing you with the best possible care. Your clear understanding of our Financial Policy is important to our professional relationship. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. Please ask if you have questions concerning our fees.

- All patients must complete our patient information form before seeing the physician.
- Payment is due at time of service unless prior arrangements have been made.
- We accept, cash, check, Visa, Mastercard, Discover, American Express or PayPal.

It is very important for you financially to know if your health insurance will pay for a physical exam. Some health insurance will pay for a physical exam. However, many plans will not pay at all for a physical exam and the total cost will be your responsibility. **It is your responsibility to know what your insurance will cover**, to ensure that you don't experience any unnecessary charges and we will bill appropriately for your exam.

Insurance Coverage:

Your insurance is a contract between you and your insurance company. We are not a party to that contract. If you have insurance, we will help you receive maximum benefits. If we accept your insurance, you must pay any co-payments and deductibles allowed at the time of service. In the event we accept assignments of benefits, the patient is still ultimately responsible for all the charges. If your insurance company has not paid your account in full within 45 days, the balance is due in full from the patient and/or guardian.

Usual and Customary Rates:

Our practice is committed to providing the best treatment for patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We file claims as a courtesy to our patient. We will not become involved in disputes between you and your insurance company regardless of deductibles, co-payments, covered charges, secondary insurance, etc., other than to provide factual information as necessary. **You are responsible for the timely payment on your account**.

Assignment of Insurance Benefits:

I request that payment of authorized Medicare and/or applicable insurance benefits be made on my behalf to Ozark Internal Medicine & Pediatrics for any services furnished by Ozark Internal Medicine & Pediatrics. I authorize any holder and its agent to release my medical and/or other necessary information which may be needed to determine benefits payable for the Healthcare Financing Administration and/or its agent.

Late Appointment/No Show/Reschedule Policy:

Patients who are more than 15 minutes late for an appointment will be asked to reschedule, unless *at the provider's discretion only*, the provider's schedule can accommodate the late arrival. Patients who reschedule their appointment twice or "no-show" an appointment, will be charged a **$25.00** fee at the patient's next scheduled visit. If the patient is a "no-show" and does not cancel within 24 hours before the scheduled visit, a $25.00 fee will be collected at the patient's next scheduled appointment. There are exceptions which are at the *office manager's discretion*. If you have questions, please speak with the clinic office manager prior to being seen by the physician.

Patients have the right to refuse service or treatment and Ozark Internal Medicine and Pediatrics has the right to refuse service.

Paperwork Fee:

There will be a $15.00 charge in advance for filling out paperwork not related to patient's permanent medical record or related to the processing of patient claims paid directly to Ozark Internal Medicine & Pediatrics, (i1e. FLMA Forms, AFLAC, Disability Papers, etc.)

If you do not provide us with a copy of your insurance card today, you should be prepared to pay for your services today.

_____ _____

Responsible Party's Signature **Date**

Ozark Internal Medicine & Pediatrics
Notice of Privacy Practices/HIPPA Privacy Services

Patient's Name: _____

OZARK INTERNAL MEDICINE & PEDIATRICS is committed to providing security for patient privacy and confidentiality. This organization collects, uses, and discloses personal health information only in conformance with State and Federal information available, such as medication and prescription history and verification of insurance eligibility. 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 have reviewed a copy of the **OZARK INTERNAL MEDICINE & PEDIATRICS** Notice of Privacy. I hereby consent to all the uses and disclosures in my Health Care Provider's Notice of Privacy Practices.

OZARK INTERNAL MEDICINE & PEDIATRICS also realizes the patient may have family members or significant people who the patient may wish to have access to certain information contained in the patient's medical records. Without your written permission, we cannot release any information to anyone except for purposes outlined in the HIPAA privacy act. **OZARK INTERNAL MEDICINE & PEDIATRICS** also uses an automated system to remind the patient of appointments, health maintenance reminders, prescriptions, and lab results. **We will contact the patient using the last contact information on file**. Please update the following contact information:

Email (Patient Portal): _____
Home Phone: _____
Cell Phone: _____

( ) I do want to receive phone messages and patient portal messages from my provider.
( ) I do NOT wish to receive phone messages and patient portal messages from my provider.
IF AN OPTION IS NOT CHOSEN, WE WILL BE UNABLE TO CONTACT YOU.

Please provide the people age 21+ who can receive patient's public health information, authorize treatment, and their relationship to the patient:

Individual's Name	DOB	Phone Number	Relationship to you (or to minor)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____I request that this authorization never expire. I may revoke my authorization in writing by contacting Brooke Davies, the privacy officer.

_____ _____
Patient's Signature (if age is 18 or older Date

_____ _____ _____
Signature or Patient's Representative/Guardian Relationship to Patient Date

OZARK INTERNAL MEDICINE & PEDIATRICS
AUTHORIZATION OF CONSENT FOR
TREATMENT OF A MINOR

I hereby authorize the following to consent to medical treatment (routine or emergency) for _____, a minor for whom I am legally responsible. I am fully aware that by signing this authorization, I am giving _____, permission to render routine or emergency care with the consent of the following people.

(Please specify Name and Relationship to the minor.)

Immediate Family:

_____

_____

_____

_____

Extended Family:

_____

_____

_____

_____

Other:

_____

_____

_____

_____

SIGNATURE:

_____

DATE:

_____

OZARK INTERNAL MEDICINE & PEDIATRICS

Authorization to Give Medical Care

Consent to Treatment

I hereby voluntarily consent to outpatient care from **OZARK INTERNAL MEDICINE & PEDIATRICS** encompassing routine diagnostic procedures, examination and medical treatment including (but not limited to) routine laboratory work, taking of x-ray, heart tracing, and administration of medications prescribed by the providers. I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by **OZARK INTERNAL MEDICINE & PEDIATRICS** medical staff and their assistants or designees, as is necessary in the medical staff's judgment. I understand that this consent will be valid and remain in effect as long as I (he/she) attend the clinic.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize **OZARK INTERNAL MEDICINE & PEDIATRICS** to release any information acquired in the course of my examination or treatment to any authorized agent for the purposes of treatment, payment, and healthcare.

ACKNOWLEDGEMENT:

I acknowledge that I am responsible for my account balances and the balance of my spouse.

NOTIFICATION OF PRIVACY:

I have read the **OZARK INTERNAL MEDICINE & PEDIATRICS** Health Information Portability and Accountability Act (HIPPA) and understand the information contained within it.

AUTHORIZATION TO ACCESS RX HISTORY INFORMATION:

I hereby authorize **OZARK INTERNAL MEDICINE & PEDIATRICS** to access historical prescription drug information.

AUTHORIZATION TO PAY BENEFITS:

I authorize **OZARK INTERNAL MEDICINE & PEDIATRICS** to file my insurance for services rendered. I understand that insurance is filed as a courtesy and that I am responsible for payments of all services within 90 days. I also authorize the release of all medical information to my insurers. I authorize payment of medical benefits by any insurance to wither **OZARK INTERNAL MEDICINE & PEDIATRICS** or myself.

MEDICARE AUTHORIZATION (this is a one-time authorization for Medicare patients only.):

I authorize any holder of medical information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carries any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that it is mandatory to notify the healthcare provider of any other part who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 3801-3812 provides penalties for withholding information). Regulations pertaining to Medicare assignment of benefits may apply.

MEDI-GAP AUTHORIZATION:

I authorize any holder of medical or other information about me to release to **OZARK INTERNAL MEDICINE & PEDIATRICS** any information needed for this or any related Medi-gap claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either or to the party who accepts the assignment. I understand that **OZARK INTERNAL MEDICINE & PEDIATRICS** may not accept assignments on all Medi-gap insurances. I agree to be responsible for any deductible and copay that is not covered by my Medi-gap insurance.

This form has been fully explained to me and I understand its contents.

PLEASE SIGN FOR PERMISSION TO TREAT AND AGREEMENT TO ABOVE.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

Ozark Internal Medicine and Pediatrics
P.O. Box 429, Clinton Arkansas 72031
501-745-3033 / 501-745-8099 (Fax)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
(ALL SECTIONS MUST BE COMPLETED)

Option 1 *(Ozark Internal Medicine & Pediatrics will send your records to another facility)*:

I hereby authorize ***Ozark Internal Medicine and Pediatrics*** and its physicians employees and agents ***to release or disclose to the following clinic/facility***:_____/Fax Number:_____ all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Patient Name: _____ Date of Birth: _____ Phone: _____

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Option 2 (*Ozark Internal Medicine & Pediatrics will retrieve your records from another facility***):**

I hereby authorize ***the following clinic/facility***:_____/Fax Number: _____ and its physicians employees and agents ***to release or disclose to Ozark Internal Medicine and Pediatrics*** all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Patient Name: _____ Date of Birth: _____ Phone: _____

****

Purpose of disclosure: _____

The authorization will expire on: _____
(Date or Event may not exceed one year)

This request and authorization applies to:

_____ All medical records

_____ Health care information relating to the following treatment, condition, or dates of treatment:
_____
_____

_____ Specific records to be released (eg. Labs, imaging reports, other):
_____

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.

_____Substance abuse _____ Psychological or psychiatric treatment ____HIV/AIDS/STD

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____ _____ _____
Signature of Patient or Authorized Representative Date Signed (Relationship to Patient)

OZARK INTERNAL MEDICINE AND PEDIATRICS

NAME: _____ DATE OF BIRTH: _____

PAST MEDICAL HISTORY: (LIST ANY MEDICAL PROBLEMS YOU ARE CURRENTLY BEING TREATED FOR.)

PAST SURGICAL HISTORY: (LIST ANY SURGERIES YOU HAVE HAD AND YEAR IT WAS DONE.)

HOSPITALIZATIONS: (LIST THE REASON AND THE YEAR YOU WERE HOSPITALIZED.)

EMERGENCY ROOM VISITS WITHIN THE LAST 6 MONTHS: (LIST THE REASON AND THE FACILITY)

FAMILY HISTORY: (LIST ANY MEDICAL PROBLEMS OF YOUR PARENTS, SIBLINGS, OR CHILDREN.)

PLEASE ANSWER THE FOLLOWING AS THEY APPLY TO YOU:

WHEN WAS YOUR LAST PAP SMEAR? _____

WHAT FACILITY WAS THIS PROCEDURE PREFORMED AT? _____

WHEN WAS YOUR LAST MAMMOGRAM? _____

WHAT FACILITY WAS THIS PROCEDURE PREFORMED AT? _____

WHEN WAS YOUR LAST COLONOSCOPY? _____

WHAT FACILITY WAS THIS PROCEDURE PREFORMED AT? _____

WHEN WAS YOUR LAST PROSTATE EXAM? : _____

WHAT FACILITY WAS THIS PROCEDURE PREFORMED AT? _____

PLEASE LIST ALL THE MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

_____

_____

_____

_____

DO YOU HAVE ANY ALLERGIES? IF SO, PLEASE LIST: _____

_____

_____

REVIEW OF SYSTEMS

(CIRCLE ANY THAT APPLY TO YOU NOW OR IN THE PAST 6 MONTHS AND CIRCLE YES OR NO)

FEVER, CHILLS, WEIGHT LOSS, HEADACHE	YES	NO
EYE PAIN, BLURRY VISION, DOUBLE VISION, EAR INFECTION, SORE THROAT, NASAL CONGESTION	YES	NO
WHEEZING, COUGHING, SHORTNESS OF BREATH, SEASONAL ALLERGIES	YES	NO
CHEST PAIN, HEART FLUTTERING, WAKING UP AT NIGHT SHORT OF BREATH	YES	NO
ABDOMINAL PAIN, DIFFICULTY SWALLOWING, NAUSEA, VOMITING, HEARTBURN, BLOOD IN STOOL	YES	NO
PROBLEMS WITH URNIATION, PAINFUL URINATION, URINATED MORE FREQUENTLY	YES	NO
TREMORS, DIZZY SPELLS, NUMBNESS, TINGLING, DEPRESSION, SUICIDE CONSIDERATIONS	YES	NO
EXCESSIVE THIRST, HEAT OR COLD TOLERANCE	YES	NO
JOINT PAIN, NECK PAIN, BACK PAIN, MUSCLE WEAKNESS	YES	NO
SKIN RASHES, BOILS	YES	NO
BLOOD CLOTTING PROBLEMS, BLEEDING PROBLEMS	YES	NO

PARENT/GUARDIAN SIGNATURE: _____DATE: _____

DOCTOR SIGNATURE: _____ DATE: _____