CONWAY REGIONAL HEALTH SYSTEM

Clinton Medical Clinic
Conway Medical Group
Conway Regional After Hours Clinic
Conway Regional Medical Clinic- Pottsville
Conway Regional Medical Clinic- Prince St.
Conway Regional Medical Clinic- Russellville
Conway Regional Medical Clinic- Vilonia
Mayflower Medical Clinic
Greenbrier Family Medicine

Patient Information

Patient Name: _____ _____ _____
First MI Last

Date of Birth _____ **Sex (M) (F)** **SS#** _____ **Marital Status M S W D**

Preferred Language: _____ **Race:** African American Asian Caucasian Hispanic Native American Other

Ethnicity: Hispanic Non Hispanic

Home Phone (___) _____-_____ **Cell Phone (___)** _____-_____ **Work Phone (___)** ____-_____

Mailing Address: _____
Street City State zip

E-mail Address: _____

Pharmacy: _____ **Address:** _____

Guarantor Information

Responsible Party: _____ _____
First MI Last

Date of birth _____ **SS#** _____ **Relationship** _____

Home Phone (___) _____-_____ **Cell Phone (___)** _____-_____ **Work Phone (___)** ____-_____

Primary Insurance

Name of Insurance: _____ **Phone (____)** _____-_____

ID#: _____ **Group#** _____

Name of Policy Holder: _____
First MI Last

Subscriber's Date of Birth: _____ **SS#**_____ **Relationship** _____

Medication Insurance if Different: _____

Secondary Insurance

Name of Insurance: _____ **Phone (____)** _____-_____

ID#: _____ **Group#** _____

Name of Policy Holder: _____
First MI Last

Subscriber's Date of Birth: _____ **SS#**_____ **Relationship** _____

EMERGENCY CONTACT INFORMATION

______________________________	________________________	________________________
Name	**Relationship**	**Phone Number**

____

SIGNATURE OF PATIENT **OR** GUARDIAN (if minor)

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

I do hereby authorize Conway Regional Health System to release any and all information to the name/names listed below. I understand that on release of this information, Conway Regional Health System cannot guarantee confidentiality on behalf of those that received the information.

______________________________		________________________
Name of Primary Care Physician		**Phone Number**

______________________________	________________________	________________________
Name of person to release information	**Relationship**	**Phone Number**
______________________________	________________________	________________________
Name of person to release information	**Relationship**	**Phone Number**
______________________________	________________________	________________________
Name of person to release information	**Relationship**	**Phone Number**

____	________________
Signature of patient	**Date**

Patient Medical Information

Name: _____ **Date of Birth _____/_____/_____**

Name of Primary Care Physician: _____

Phone Number of Primary Care Physician: _____

Medication and Food Allergies

○ No Known Allergies
List all known allergies (DRUGS AND FOOD)
1.
2.
3.
4.

Medications

○ I do not take any medications		
List all medications you take, prescription and nonprescription, dosage and directions on bottle.		
Medication Name	**Dosage**	**Directions on bottle**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Medical History

Marital Status M S W D

Please check if you have ever experienced any of the following condition, and year of onset			
Condition	**Year**	**Condition**	**Year**
○ None		○ Asthma	
○ High Blood Pressure		○ Allergies	
○ High Cholesterol		○ Anemia	
○ Heart Attack		○ Reflux disease (GERD)	
○ Congestive Heart Failure		○ Irritable bowel syndrome	
○ Other Heart Problems **(Be Specific)**		○ Diverticulosis	

○ Diabetes (type) _____		○ Autoimmune disorder (Ex. rheumatoid arthritis, lupus, ect. **Be Specific**)	
○ Thyroid Problems		○ Stroke	
○ COPD		○ Cancer (type _____)	
○ Other Conditions			

Please list any surgeries and/or procedures you have had in the past along with the year it was completed: (Include biopsies and cesarean section)

_____ _____

_____ _____

_____ _____

Family History

If any blood immediate family member has suffered from the following conditions, check the box and indicate which relative (mother, father, sibling, maternal grandparent, paternal grandparent ect.)

	Father	Mother	Grandparent	Sibling		F	M	GP	S
○ Heart Disease					○ Stroke				
○ Diabetes					○ High Blood Pressure				
○ Thyroid					○ High Cholesterol				
○ Asthma					○ Lung Disease				
○ Cancer (Type:_____)					○ Glaucoma				

Do You Smoke? Y N If yes: How much per day _____pack Number of years? _____

Have you smoked in the past? Y N How much per day _____pack Number of years?_____

Do You Drink Alcohol Y N If yes number of drinks per week _____ Type _____

Do You use Controlled Substances? Y N

<u>Female Patients Only</u>:

Number of Children: _____ How many Pregnancies: _____ Number of Miscarriages: _____

When was last pap smear? _____ Where was it performed? _____

When was your last mammogram? _____ Where was it performed?

_____<u>Male Patients Only</u>:

Date of last: Prostate Exam: _____ Last PSA (Prostate Blood Test): _____

CONWAY REGIONAL HEALTH SYSTEM
CONSENT FOR MEDICAL TREATMENT

PATIENT NAME: _____

I understand, authorize and consent to the rendering of medical care, including laboratory procedures, x-ray examinations, medical surgical treatments by authorized members of Conway Regional Health System, or their designees, as may in their professional judgment be necessary for the above named patient.

The patient is under the care of the physician and/or nurse practitioner, and the clinic shall not be held liable for any non-negligent act or omission when following the instructions of said physician or registered nurse practitioner or designees.

I acknowledge that no guarantees have been made as to the effect of such examinations of treatment.

PRIVACY NOTICE ACKNOWLEDGEMENT: I hereby acknowledge that I have received the Notice of Privacy Practice for Conway Regional Health System and its medical staff.

RELEASE OF INFORMATION: I hereby authorize physician to release any information acquired in the course of my examination or treatment to insurance companies or other health care providers.

PATIENT SIGNATURE

*****Signature is required at least one (1) time per year*****

_____ _____ _____

Patient Signature **Date** **Witness**

SIGNATURE OF PATIENT REPRESENTATIVE

If the undersigned is signing as patient's representative, he hereby certifies that the patient is not personally able to sign because of:

_____

(List minor, mental/physical incapacity)

And that the undersigned bears the relationship of: _____ to the patient.

The agent is legally authorized to execute the above and accept its terms. If the undersigned is signing as patient's agent, he hereby certifies that the patient has expressly appointed him to act as patient's agent.

_____ _____ _____

Patient's Agent Signature **Date** **Witness**

CONWAY REGIONAL HEALTH SYSTEM
Patient Account Financial Policy

This Material is being distributed to let you know how your account with our Clinic will be processed. It is our hope that with this knowledge, the burden of worrying about how you will pay for your medical services will be lessened.

Generally, our patients fall into three categories for billing purposes. These categories are as follows:

New Patients: Fees for Medical services are due at time service is rendered. All new patients are expected to pay their full balance at the time of the first visit and any visits occurring in the next 45 days.

Patients With Health Insurance Coverage: Fees for medical services are due at time service is rendered. Our Clinic will file all claims for Medicaid, Medicare, and certain managed care insurances for which we are a participating provider. As a COURTESY to our patients, we can file directly with certain other insurance carriers. Please check with our insurance clerk to see if we can file your insurance claim for you.

The Clinic will accept assignment of qualifying insurance benefits in lieu of payment for a period of 45 days after we have filed the insurance. If your insurance company has not paid on your account within 45 days, the account reverts to SELF PAY status and it will be necessary for you to make arrangements to secure your account. Staying in contact with your insurance carrier while the claim is in process will help to assure that the claim will be processed in a timely manner.

After your insurance has settled their portion of your account, you have an additional 30 days to remit the balance. In order to avoid a hardship, we recommend that you begin making payment on your portion of the bill even before your insurance has paid. Should an overpayment arise, it will be promptly refunded to the appropriate party. Accounts not settled within the prescribed 30 day time frame may be subject to referral to third party collections. **Any accounts referred to a third-party collection agency, will be charged an additional 18% to the balance to cover collection agency fees.**

Should an insurance payment ever be made directly to you, your balance with the Clinic shall be due in 10 days.

Patients With No Health Insurance Coverage: Fees for medical services are due at time service is rendered. For some clinical services, a pre-paid deposit may be requested.

I acknowledge the above said policy. I also understand that in the event that my account/accounts should be referred to a third party collection agency, the appointed agency will serve as a collector for such debt and use diligence in collection of said debts including but not limited to telephone calls, and correspondence as not to violate any applicable state or Federal laws or any amendment thereto.

Thank you for using the services of Conway Regional Health System.

_____ _____

Patient Signature **Date**

CONWAY REGIONAL HEALTH SYSTEM
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTHCARE INFORMATION

PLEASE INITIAL:

_____ I hereby authorize and request:

_____

_____

_____

To furnish all information concerning my history and treatment, examinations, or hospitalizations, including all copies of medical records to:

_____

_____

_____

_____ This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon and if not earlier revoked it shall terminate six months from the date of consent without express revocation.

_____ I understand that the information on my health records 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.

_____ I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations

Patient Name: _____

Date of Birth: _____ S.S#: _____

Signature: _____ Date: _____

Witness Signature: _____

Authorization must be signed by the patient or legal representative in the case of a minor or when patient is physically or mentally incompetent. In the event patient is requesting medical records information, verify receipt of medical records by signature.

Signature: _____ Date: _____