Northwest Arkansas Pediatric Clinic, P.A.
A MANA Clinic

PATIENT REGISTRATION

www.mana.md

Internal Use Only
_____

mana medical associates

PATIENT INFORMATION – Please Print

Patient's Legal Name_____Preferred name: _____ Date _____

Sex: ☐M ☐F Date of Birth _____ Social Security #_____

Allergies_____

Race: ☐ White ☐ African American ☐ Asian ☐ Native Hawaiian/Other Pacific Islander

☐ Native American Indian/ Alaskan ☐ Other Race _____

Ethnicity (Origin): ☐ Not Hispanic or Latino ☐ Hispanic or Latino Preferred (Primary) Language: _____

Sibling _____ DOB_____ Sibling _____ DOB_____

Sibling _____ DOB_____ Sibling _____ DOB_____

Primary Physician _____

Preferred Pharmacy_____ Street_____

Appointment Reminder: Please select how you would like to be notified of your appointment. You may select more than one option. ☐ Email ☐ Text ☐ Phone call

Message and data rates may apply for text messages. To change your preferences, you may update your information at the receptionist desk at anytime.

PERSON RESPONSIBLE FOR PAYMENT

GUARDIAN(S) / FOSTER PARENT(S): Please complete the parent information and indicate that the child is in your custody.

Responsible Party _____

Address_____ Apt _____ City_____ State____ Zip_____

Home Phone _____ Mobile _____ Preferred: ☐Home ☐Mobile

Father's Name _____ DOB _____ SS# _____

Employer _____ Work Phone _____

Mother's Name _____ DOB _____ SS# _____

Employer _____ Work Phone _____

Please check one: ☐ Married ☐ Single ☐ Partner ☐ Divorced ☐ Widowed ☐ Separated

EMAIL AUTHORIZATION

Email Address _____

By providing my email address above, I hereby agree to allow MANA to contact me by email with e-newsletters, wellness reminders, health news and updates regarding health-related services provided by MANA. I understand that MANA will not share the information provided above with outside marketing companies.

EMERGENCY CONTACT INFORMATION

Relative or Friend not in the home

Emergency Contact _____ Relationship to Patient _____

Phone_____ Address_____ City_____ State__ Zip_____

➔➔ **Please complete the BACK of the form** ➔➔

HEALTH INSURANCE INFORMATION

Please provide a copy of your insurance card to the receptionist.

ARKids First or MEDICAID ☐ No. _____ Effective Date _____

PRIMARY INSURANCE _____

ID#_____ GP#_____ Phone#_____

Address_____ City_____ State_____ Zip_____

Policy Holder's Name _____ DOB_____ SS#_____

Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Other

SECONDARY INSURANCE _____

ID#_____ GP#_____ Phone#_____

Address_____ City_____ State_____ Zip_____

Policy Holder's Name _____ DOB_____ SS#_____

Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Other

INSURANCE AUTHORIZATION AND / OR FINANCIAL AGREEMENT

I hereby authorize Medical Associates of Northwest Arkansas (MANA) to give my insurance company or companies all information they may require concerning my case, and I hereby assign to the physician(s) all payments for medical services rendered.

I understand that I am responsible for any amount not covered by insurance. I agree to pay any co-pay and amount due at the time of service.

Signed_____ Date_____

PATIENT NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received a copy of the Patient Notice of Privacy Practices from Medical Associates of Northwest Arkansas.

SIGNATURE_____ **DATE** _____

In the event this Acknowledgement form is being executed by a personal representative, guardian or parent, please print your name, date of birth, social security number and relationship to the patient here:

_____

If you would like to authorize MANA clinic to release information to a **family member, spouse, or personal representative**, please complete an **Individual Authorization Form** provided by the receptionist.

HOW DID YOU HEAR ABOUT US?

01 ☐ Recommended by a friend or family member.
02 ☐ Clinic web site, www.mana.md
03 ☐ Other web site _____
04 ☐ E-mail, Facebook or Twitter
05 ☐ Signs or location
06 ☐ Kids Directory Magazine
07 ☐ My employer
08 ☐ Citiscapes Magazine
09 ☐ Newspaper
10 ☐ Yellow Pages / phone directory
11 ☐ Received a postcard in the mail.
12 ☐ Referred by Doctor _____
13 ☐ Found the doctor listed in my Insurance directory.
14 ☐ Other *Please specify*_____

Thank you for choosing a MANA Clinic.

Northwest Arkansas Pediatric Clinic
Health History

Child's Name_____ Birthdate ___/___/____Today's Date ___/___/___

Your child's overall health, family history and their home environment can be very important information to aid in providing them excellent health care. Please answer all questions completely and accurately. Please realize that each child in a family needs their own history completed. We apologize for any inconvenience.

To the best of my knowledge, the questions on this form are answered accurately. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the doctor's office of any changes in my child's medical status. I also authorize the healthcare staff to perform the necessary services my child needs.

Signature of Parent/Guardian _____ Date ___/___/_____

If you are bringing your child for a newborn visit, please complete ONLY sections 1, 2 and 3, otherwise, please answer all questions.

1: Birth History

Birth Weight _____ lbs. _____ oz. Weeks gestation _____

Complications: None ☐ _____

2: Social History

Who all lives in the child's home?

Mother ☐ Father ☐ # of Siblings_____ Extended Family members _____

Who provides childcare (check all that apply) Parent ☐ Grandparent ☐ Daycare ☐ School ☐

In-Home Daycare ☐ Gym ☐ Mother's Day Out ☐ Other _____

Does anyone living with or caring for your child smoke cigarettes at any time? No ☐ Yes ☐ IF CHILD IS > 13 years old, do they smoke? No ☐ Yes ☐

At your home do you have: City Water ☐ Well Water ☐

3: Family Medical History

Please mark any diseases known to have occurred in the family with the appropriate initial:
(M) Mother, **(F)** Father, **(B)** Brother, **(S)** Sister, **(EF)** Extended Family

_____ Asthma	_____ Cancer	_____ Hearing Problems	_____ Migraines	_____ Stomach Problems
_____ Alcoholism	_____ Cholesterol	_____ High Blood Pressure	_____ Obesity	_____ Stroke
_____ Bleeding Disorder	_____ Developmental Problems	_____ Kidney Problems	_____ Seasonal Allergies	_____ Other _____
_____ Blood Clotting Disorder	_____ Diabetes	_____ Mental Illness	_____ Seizures	_____

☐ No Significant Family Medical History

4: Past Medical History

Has your **child** ever been diagnosed with any of the following? Please mark all that apply

_____ Allergies	_____ Congenital Heart Defect	_____ HIV/AIDS	_____ Seizures
_____ Asthma/Wheezing	_____ Eczema/Skin Problems	_____ Hemophilia	_____ Tuberculosis
_____ Cancer	_____ Frequent Ear Infections	_____ Mental Illness	_____ Urinary Tract Infections
_____ Chicken Pox	_____ Heart Murmur	_____ Prematurity: # weeks gestation ____	_____ Other _____
_____ Diabetes	_____ High Cholesterol	_____ Rheumatic Fever	_____

☐ Previously Healthy

5. Past Surgical/ Hospitalization History

Please list all hospitalizations and/or surgeries including age at time of surgery and hospital, including city and state if needed:

_____

_____

_____

6: Allergies

Please list all drugs to which your child is allergic as well as the reaction they had when exposed.

_____

_____

_____

mana
medical associates

Medical Associates of Northwest Arkansas (MANA)

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page the next page (2) / back page.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We do not market or sell personal information.
We do not create or maintain psychotherapy notes at this practice.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Medical Associates of Northwest Arkansas (MANA)
Privacy Officer:
Paula Maxwell, Chief Operating Officer
3383 N. MANA Court, Suite 201
Fayetteville, AR, 72703
Phone: (479) 571-6780
Email: privacyofficer@mana.md

Effective Date: September 23, 2013

Authorization For Release of Protected Health Information

I,_____, give all physicians and professional staff employed by Medical Associates of Northwest Arkansas, P.A. permission to disclose the protected health information set forth below to the following people at the request of one or more of these individuals.

Patient name (print):_____ **D.O.B.** _____

Information to be released to the below referenced entity:

☐ **Complete Medical Record** ☐ **or specific information:** _____

_____

Please Print: **Name** **Relationship to Patient**

_____

_____

_____

I give Medical Associates of Northwest Arkansas P.A., permission to:

- Fax my child's **School Excuse** to his/her school.
  ☐ **Yes** ☐ **No**
- Leave a message (s) on my answering machine if they should need to remind me of an appointment, change an appointment, etc, and are unable to reach me in any other way.
  ☐ **Yes** ☐ **No**

In addition, I understand or acknowledge the following:

1. I understand that Medical Associates of Northwest Arkansas, P.A ., will not release any information to any person(s) not listed above.
2. I have the right to revoke this Authorization at any time by giving Medical Associates of Northwest Arkansas, P.A., a written notice. I understand this does not apply to the release of PHI pursuant to my prior authorization.
3. I have received Medical Associates of Northwest Arkansas's Notice of Privacy Practices
4. My protected health information may be subject to re-disclosure by one or more of the persons named above and as such may no longer be protected by federal or state law.

This authorization shall expire on the _____ day of _____, 20_____ and/or the following **Event**_____

Patient Signature:_____**DATE:**_____

In the event the Authorization is being executed by a personal representative, guardian, or parent, please print your name, relationship to the patient, and basis of authorization to act on the patient's behalf.

Print name _____**Relationship to Patient**_____

What is your authorization to act on the patient's behalf?_____

Signature _____ **Date** _____

mana
medical associates

Revised 1/02/14 cbm