HealthStar
PHYSICIANS OF HOT SPRINGS

Patient Registration Form

Last Name: _____ First Name: _____ Middle Name: _____
Preferred Name: _____
Previous Name (if applicable): _____
Date of Birth (MM/DD/YYYY): _____
Sex: _____ Male _____ Female
Social Security Number: _____

Street Address: _____
City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____
Work Phone: _____ Email: _____
Contact Preference: (Mobile / Home / Work) Consent to Text Messages (Yes/No)

Preferred Pharmacy: _____
Primary Insurance: _____
Insurance ID Number: _____
Group Number: _____
Policy Holder Name: _____
Policy Holder Date of Birth: _____

Primary Language: _____English _____Spanish _____Other
Race: _____ Ethnicity: _____ Marital Status: _____
Emergency Contact Name: _____Phone: _____

Guardian Name (if patient is a minor): _____
Relationship: _____

Guarantor Name (financially responsible for minor patient*): _____
Relationship: _____ Phone: _____
*Legal documents/court orders may be required

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize the release of information concerning mine/my child's healthcare, advice or treatment used for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payment to me directly to HealthStar Physicians Group, PLLC.

_____ _____
Signature of Patient or Guardian Date

HealthStar
PHYSICIANS OF HOT SPRINGS

PATIENT HISTORY FORM

(Please fill in as much as possible)

Patient Name: _____ **Date of Birth:** _____ **Height:** _____ **Weight:** _____

Reason for visit today: _____

Previous PCP and Specialists (list any primary care or specialists, such as cardiology, orthopedics, pulmonary, etc):

_____

List all drug and non-drug allergies: _____

List all current prescription medications:

Name	Dose (mg)	How Often	Name	Dose (mg)	How Often

List all current and past medical conditions:

_____

List all past surgeries and procedures:

Date:	Specify type of surgery and body location:	Performing physician:

List any family medical history:

Father: _____ Paternal Grandfather: _____
Mother: _____ Paternal Grandmother: _____
Brother: _____ Maternal Grandfather: _____
Sister: _____ Maternal Grandmother: _____

Personal History:

Do you smoke? Yes or No How much per day? _____ For how long? _____ Quit date? _____
Do you use smokless tobacco? Yes or No How much per day? _____ For how long? _____
Do you drink alcohol? Yes or No How often? _____ Type of alcohol _____
Have you ever tested positive for any STD's or communicable diseases? _____ If yes, list _____
Do you have any history of substance use or abuse? Yes or No If yes, list _____

(All of the above information is to enable us to provide you with better healthcare. It is part of your private medical record and is not shared with anyone without your express permission.)

Marital Status: _____ Any children & how many? _____

Are you currently employed? _____ What type of work and where? _____

HEALTHSTAR PHYSICIANS

"DEDICATED TO QUALITY HEALTHCARE"

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT

I, _____, have received a copy of
(PLEASE PRINT YOUR NAME ABOVE)
The HealthStar Physicians of Hot Springs Notice of Privacy Practices.

_____ _____
Signature of Patient or Legal Guardian Date

FOR OFFICE USE ONLY

PATIENT WAS OFFERED THE HIPAA PRIVACY NOTICE:

_____ Refused _____ Accepted

Patient Account Number: _____ Employee's Initials: _____

Notes: _____

_____

HealthStar
PHYSICIANS OF HOT SPRINGS

HIPAA Notice of Privacy Practices Acknowledgement & Virtual Scribe Consent

Patient Name: _____ DOB: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with, or offered, a copy of the Notice of Privacy Practices describing how my protected health information (PHI) may be used and disclosed in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

I understand that my health information may be used for treatment, payment, and healthcare operations. I understand that I have rights regarding my PHI, including the right to access, request amendments, and request restrictions, subject to applicable law.

ACKNOWLEDGEMENT OF USE OF VIRTUAL SCRIBE / DOCUMENTATION SERVICE

To support accurate clinical documentation and effective patient–provider communication, providers in this practice may use a secure Virtual Scribe service to aid in the documentation of your visit. The Virtual Scribe's role is limited to documentation support only and does not include participation in your care, diagnosis, or treatment decisions. All information is protected in accordance with HIPAA privacy and security standards.

If you prefer not to have a Virtual Scribe used during your visit, please notify our staff and your provider at any time. Your decision will not affect your care

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION (PHI)

I authorize this practice to discuss my protected health information with the following individuals:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

This authorization is voluntary and remains in effect until I revoke it in writing.

PATIENT ACKNOWLEDGEMENT AND SIGNATURE

Patient or Legal Representative Signature: _____

Printed Name: _____

Relationship (if not patient): _____ Date: _____

Financial Policies and Procedures Agreement

HealthStar Physicians of Hot Springs — Patient Acknowledgment and Consent Form

Welcome to our HealthStar Physicians of Hot Springs. Our commitment is to provide high-quality healthcare in a compassionate, transparent environment. To ensure clarity and mutual understanding, we ask all patients to review and sign this Financial Policies and Procedures Agreement. This document outlines your responsibilities and our procedures related to billing, insurance, payments, and medical records. If you have any questions about these policies, our staff is available to assist you.

By signing this agreement, you acknowledge that you have read, understood, and agreed to the following terms:

1. Payment at Time of Service

Policy: All patients are expected to pay for services rendered at the time of their appointment, unless prior arrangements have been made with our billing office. This includes copays, coinsurance, deductibles, and any outstanding balances from previous visits.

Procedures:

- Payments can be made by cash, check, debit, credit card, or HSA card.
- Patients with commercial or private insurance must pay their plan-required copay and/or coinsurance at check-in.
- Any outstanding balances must be paid before scheduling future appointments unless a payment plan is in place.

2. Fees and Collections

Our fees are based on the complexity of your visit and the procedures performed. We strive to keep our fees competitive and transparent.

Collections Policy:

- Accounts not resolved within 60 days may be referred to an outside collection agency.
- Patients are responsible for all costs associated with collection efforts, including reasonable attorney fees.
- If your account is sent to collections, you may be discharged from the practice.

3. Copays and Deductibles

Policy: Copays and deductibles are determined by your insurance carrier. It is your responsibility to know your plan's requirements.

Procedures:

- Copays are collected at the time of service.
- Deductibles and coinsurance amounts will be billed after your claim is processed by your insurance company.
- If your deductible has not been met, you may be asked to pay estimated charges for your visit.

4. Required Patient Health Insurance Policy or Summary Plan Description

Policy: All patients with commercial or private insurance must provide a current insurance card and, if requested, a summary plan description.

Procedures:

- Please bring your insurance card to every visit and notify us promptly of any changes in coverage.
- Failure to provide accurate insurance information may result in denied claims and full patient responsibility for charges.
- We recommend that you familiarize yourself with your policy's benefits, limitations, and exclusions.

5. Placing a Credit or Debit Card on File

Policy: For convenience and security, we require a valid credit or debit card to be placed on file for all patients.

Procedures:

- Your card will be securely stored and only charged for authorized outstanding balances.
- Your insurance will be billed and after payment according to your policy, you will receive an email 5 days prior to your card being charged for any remaining balance you are responsible for. If there is not a remaining balance, you will not be notified. If you do not put an email on file, you will not be notified, but your card will be charged.
- You have the right to pay with an alternate method within the 5 days.
- If your payment method cannot be processed for any reason, please contact us to make other arrangements.
- Patients with Medicare, Medicare Advantage/Supplements, Medicaid, Medicaid PASSE, or ARKids are exempt but must pay applicable copays and pre-determined costs.

6. Under Aged Guarantor

Policy: For patients under the age of 18, a parent or legal guardian is required to act as the financial guarantor. The guarantor assumes full responsibility for the payment of all services to the minor, including copays, coinsurance, deductibles, and outstanding balances.

Procedures:

- A parent or legal guardian must be present at registration to provide information and sign as guarantor.
- The guarantor will receive all billing statements and is responsible for prompt payment according to our financial policies outlined in this document.
- If custody or guardianship arrangements exist, documentation must be provided to clearly establish the party responsible for billing purposes.
- All payment arrangements, including payment plans, must be made by the guarantor on behalf of the minor patient.

7. Elective Procedure/Non-Covered Procedures

Policy: Procedures deemed elective or non-covered by your insurance plan must be paid in full at the time of service.

Procedures:

- We will provide an estimate of charges prior to your procedure.
- It is your responsibility to confirm coverage with your insurance carrier.
- If your insurance denies a claim for non-covered services, you will be responsible for payment.

8. Submission of Claims

Policy: As a courtesy, we submit claims to contracted commercial and private insurance plans. Submission does not guarantee payment or coverage.

Procedures:

- We will submit claims based on the information you provide.
- If your plan rejects or denies a claim, you will be billed for the full amount.
- Patients are responsible for following up with their insurance carrier regarding claims.

9. Payment Options

Policy: We accept multiple forms of payment for your convenience.

Procedures:

- Accepted payment methods: cash, check, Visa, Mastercard, Discover, American Express, HSA and FSA cards.
- Payment plans may be arranged for large balances; terms must be approved by our billing office.
- Returned checks are subject to a $30 fee.

11. Medicare Patients

Policy: We accept Medicare patients and will bill Medicare for covered services.

Procedures:

- You are responsible for Medicare deductibles and coinsurance.
- If you have supplemental insurance, please provide documentation at each visit.
- For non-covered services, payment is required at the time of service.

12. Non-Contracted or Out-of-Network Insurances

Policy: If your insurance plan is not contracted or is out-of-network, you may be responsible for higher out-of-pocket costs.

Procedures:

- We may collect payment in full at the time of service and provide you with a receipt for self-submission.
- Our staff can assist with claim forms, but reimbursement depends on your insurer's policies.

13. Self-Pay

Policy: Patients without insurance or who choose not to use insurance are considered self-pay.

Procedures:

- Self-pay patients must pay for services in full at the time of visit.
- Quotes for routine visits and procedures are available upon request.
- Payment plans may be arranged for certain services; please discuss with our billing office in advance.

14. Missed/Late Appointments

Policy: Missed/Late appointments or late cancellations impact our ability to serve patients and may result in a fee.

Procedures:

- Appointments must be canceled at least 24 hours in advance.
- Failure to cancel in a timely manner or no-shows may result in a $25 fee.
- Repeated missed appointments may result in discharge from the practice.
- If you are running late, please contact our office immediately so that we may determine whether we can see you that day or reschedule.
- Late arrivals greater than 15 minutes will be cancelled and rescheduled for another time.

15. Referrals

Policy: Certain insurance plans require referrals for specialist care.

Procedures:

- It is your responsibility to ensure that your plan authorizes referrals before scheduling with a specialist.
- We require a minimum of 3 business days to process referral requests.
- Incomplete, inaccurate, or late requests may delay care.

16. Medical Records Fees

Policy: Requests for copies of medical records are subject to fees as permitted by state and federal law.

Procedures:

- The fee is $12.50 for the first 25 pages, plus $0.25 for each additional page.
- Records will be provided within 15 business days of the request.
- Fees must be paid in full before records are released.

17. Authorization to Release Information

Policy: Patient information may be released as required for treatment, payment, and healthcare operations, or as otherwise authorized by law.

Procedures:

- By signing below, you authorize our practice to release medical and billing information to your insurance carrier, referring providers, collection agencies, and other entities as necessary for processing claims and payments.
- You may revoke this authorization in writing at any time, except to the extent that action has already been taken.
- All disclosures comply with HIPAA regulations and applicable privacy laws.

Patient Acknowledgment and Signature

I have read and understand the Financial Policies and Procedures outlined above. I agree to comply with these policies as a condition of receiving care. I understand that I am responsible for payment of services not covered by my insurance, as well as any fees assessed according to these policies.

Thank you for taking the time to review our policies. We appreciate your trust in our practice and look forward to serving you and your family's healthcare needs.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient Name (print)	Patient Signature (or responsable party)
Date of Birth	Date Signed

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE.

I hereby assign and convey directly to HealthStar Physicians of Hot Springs, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the abovenamed health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

This lifetime assignment will remain in effect until revoked by me in writing. It is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it were the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient Name (print)	Patient Signature (or responsable party)
Date of Birth	Date Signed

HealthStar Physicians of Hot Springs
Medication Policy

Please be advised that if you are on any of the following medications or are on a pain contract, or pain management from another physician, you must continue to receive your medication from that physician. **Our office WILL NOT routinely prescribe these medications.** We want to be upfront with you regarding this so that we can eliminate any confusion. There may be other medications not listed below that may also be included in this policy. This will be at the discretion of your provider.

BRAND NAME	GENERIC NAME
Xanax, Vallum, Ativan	Alprazolam, Diazepam, Lorazepam
Anexsia, Bencap HC, Ceta-Plus, Co-Gesic, Doiacet, Dolagesic, Dolorex, Forte, Duocet, Hy-Phen, Hydrocet, Hydrogesic, Lorcet, Lorcet HD, Lorcet Plus, Lortab, Margesic-H, Norco, Panacet, Polygesic, Stagesic, T-Gesic, Ugesic, Vanacet, Vicodin, Vicodin ES, Vicodin HP, Zydone	Hydrocodone
M-Oxy, OxyContin, Oxyfast, OxyIR, Percolone, Roxicodone, Endocet, Percocet, Roxicet, Rolilox, Tylox	Oxycodone
Mephergan	Meperdine
Astramorph PF, DepoDur, Duramorph, Infumorph, Kadian, Morphesian, MS Contin, MSIR, Oramorph, Roxanol, Roxanol 100	Morphine
Rela, Soma	Carisoprodol

If you have any questions, feel free to ask your provider.

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN TODAY'S DATE

HealthStar
PHYSICIANS OF HOT SPRINGS

SOCIAL NEEDS SCREENING

What is your housing situation today?

- ☐ I have housing
- ☐ I do not have housing (staying with others; in a hotel, shelter, or car; or outside)
- ☐ I choose not to answer

Are you worried about losing your housing?

- ☐ Yes
- ☐ No
- ☐ I choose not to answer

What is your current work situation?

- ☐ Full time work
- ☐ Part time or temporary work
- ☐ Unemployed and seeking work
- ☐ Unemployed but not seeking work
- ☐ I choose not to answer

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.

☐ Yes	☐ No	**Food**
☐ Yes	☐ No	**Clothing**
☐ Yes	☐ No	**Utilities**
☐ Yes	☐ No	**Child Care**
☐ Yes	☐ No	**Medicine or any health care** (medical, dental, mental, vision)
☐ Yes	☐ No	**Phone**
☐ Yes	☐ No	**Other** (Please write)

☐ I choose not to answer

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

☐ Yes ☐ No ☐ I choose not to answer

How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

☐ Less than once a week ☐ 1 or 2 times a week ☐ 3 to 5 times a week

☐ More than 5 times a week ☐ I choose not to answer

Do you feel physically and emotionally safe where you currently live?

☐ Yes ☐ No ☐ I choose not to answer

In the past year, have you been afraid of your partner or ex-partner?

☐ Yes ☐ No ☐ Unsure ☐ I have not had a partner ☐ I choose not to answer