HealthStar
PHYSICIANS OF HOT SPRINGS

PATIENT REGISTRATION FORM

LAST NAME: _____
FIRST NAME: _____
PREFERRED NAME: _____
MIDDLE NAME, SUFFIX: _____
PREVIOUS NAME: LAST: _____, FIRST _____
SEX: _____ MALE _____ FEMALE
DATE OF BIRTH: MM _____ DD _____ YYYY _____
SOCIAL SECURITY NUMBER: _____
ADDRESS: _____
ADDRESS: _____
ZIP CODE: _____
CITY: _____
STATE: _____

HOME PHONE: _____ MOBILE PHONE: _____
CONSENT TO TEXT: _____YES _____ NO WORK PHONE: _____
PREFERRED PHARMACY:_____
PRIMARY INSURANCE: _____
INSURANCE ID # _____ GROUP # _____
POLICY HOLDER NAME: _____ POLICY HOLDER DOB: _____
EMAIL: _____
CONTACT PREFERENCE: ____ HOME PHONE ____ MOBILE PHONE ____ WORK PHONE

LANGUAGE: ____ ENGLISH _____ SPANISH _____ OTHER

RACE: ___ BLACK OR AFRICAN AMERICAN ___AMERICAN INDIAN OR ALASKA NATIVE
___ WHITE ___ ASIAN ___ NATIVE HAWAIIAN ___ OTHER ___ DECLINED

ETHNICITY: ___ HISPANIC OR LATINO ___ NOT HISPANIC OR LATINO ___ OTHER ___ DECLINED

MARITAL STATUS: ___ MARRIED ___ SINGLE ___ DIVORCED ___ WIDOWED ___ PARTNER

GUARDIAN: LAST NAME: _____
FIRST NAME: _____
MIDDLE NAME, SUFFIX _____

EMERGENCY CONTACT: NAME_____
RELATIONSHIP: ___ SPOUSE ___ PARENT ___ CHILD ___ SIBLING
___ FRIEND ___ COUSIN ___ GUARDIAN ___ OTHER
HOME PHONE: _____
MOBILE PHONE: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize release of any information concerning me or 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 payable to me directly to the Doctor.

_____ _____
SIGNATURE OF PATIENT OR GUARDIAN TODAY'S DATE

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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

"DEDICATED TO QUALITY HEALTHCARE"

HEALTHSTAR PHYSICIANS OF HOT SPRINGS HIPAA
Acknowledgement of Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information or PHI about you and or your family member. The Notice contains a Patient Rights section describing your rights under the Health Information Portability and Accountability Act or HIPAA. You have the right to review our Notice before signing this acknowledgement. The terms of our Notice may change. If we change our Notice, you will be given a revised copy on your first visit to our office following the date of the revision.

Individuals Involved in Your Care or Payment for Your Care
We may disclose Protected Health Information to a person who is involved in your medical care or helps pay for your care, such as a family member or friend. But before we do that, we will provide you with an opportunity to object to and opt out of such a disclosure whenever we practicably can do so. If you would like to give us permission to speak to certain individuals, you may do so by listing them below. Please understand that it is your responsibility to update this information.

You may discuss my medical care or payment of my medical care with:

_____ Relationship _____ Telephone# _____

_____ Relationship _____ Telephone# _____

_____ Relationship _____ Telephone# _____

This consent was signed by: _____

_____ _____
Print Name (Patient or Patient Representative) Date

Relationship to Patient: _____

PATIENT WAS OFFERED THE HIPAA NOTICE PRIVACY FORM:

_____ Refused _____ Accepted

HealthStar Physicians of Hot Springs

1661 Airport Rd, Suite D
Hot Springs, AR 71913
Phone: 501-625-7500

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask any questions you may have, and sign in the space provided. A copy will be provided upon your request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service, unless prior arrangements have been made. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, all services, including medication refills, will be discontinued for you and your immediate family, and your account will be turned over to a collection agency.

8. **No Insurance/Self Pay.** Please note that if you do not have insurance or have a large deductible not met when you come to the clinic, **payment is due at the time of service**.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

My signature below confirms that I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party **Date**

My signature below confirms that I have received and read a copy of the HIPAA Notice of Privacy Practices.

_____ _____

Signature of patient or responsible party **Date**

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**

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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