COMMUNITY
FAMILY MEDICAL

Patient Information

First Name: _____ Middle Name: _____ Last Name: _____
Date of Birth: _____/_____/_____ Gender: ____ Race: _____ Ethnicity (Hispanic Y/N): _____
Address: _____
City: _____ State: _____ Zip Code: _____ Home Phone: _____
Cell Phone: _____ Consent to Call/Text to Mobile Phones: ☐ Yes ☐ No
Social Security: _____ Email address: _____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Insurance Information:

Primary Insurance: _____ Policy #: _____ Group #_____
Insured Name: _____ Insured Date of Birth: _____
Insurance Address: _____ City: _____ State: ____ Zip Code: _____
Secondary Insurance: _____ Policy #: _____ Group #_____
Insured Name: _____ Insured Date of Birth: _____
Insurance Address: _____ City: _____ State: ____ Zip Code: _____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits per appropriate assignment(s) above to the physician or organization rendering services, not to exceed the balance due of any aforementioned provider's regular charges for this period of service.

Patient or Authorized Person Signature: _____ Date: _____

Emergency Contact Information

Name: _____ Phone: _____ Relation: _____
Name: _____ Phone: _____ Relation: _____
Name: _____ Phone: _____ Relation: _____

Medical Authorizations and Release of Information

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified below disclose full and complete protected health information including the following:
___ All medical information ___Healthcare information relating to the following treatment, condition or dates:_____
Name: _____ Phone: _____
Name: _____ Phone: _____
Patient or Guardian Signature: _____ Date: _____

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MEDICAL HISTORY

Patient: _____ Date of Birth: _____

Primary Care Provider: _____ Pharmacy: _____

Allergies:

Medication/Substance: _____ Reaction: _____

Medication/Substance: _____ Reaction: _____

Medication/Substance: _____ Reaction: _____

Medication/Substance: _____ Reaction: _____

Medications:

Name: _____Dose:_____ How many at a time? _____ How often?_____

Name: _____Dose:_____ How many at a time? _____ How often?_____

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Name: _____Dose:_____ How many at a time? _____ How often?_____

Name: _____Dose:_____ How many at a time? _____ How often?_____

Name: _____Dose:_____ How many at a time? _____ How often?_____

Personal Medical History (Check if you have ever had any of the following):

___Asthma
___Angina/Chest Pain
___Anemia
___Anxiety
___Arthritis
___Cancer
___Chronic Bronchitis
___Cirrhosis
___Clotting Disorder
___COPD
___Depression
___Diabetes
___Emphysema
___Epilepsy
___Eye Disease
___Gallstones
___Heart Attack
___Headaches
___Hepatitis
___High Blood Pressure
___High Cholesterol
___HIV Positive/AIDS
___Kidney Disease
___Kidney Stones
___Migraines
___Sexually Transmitted Infection
___Stroke
___Thyroid Disease
___Tuberculosis
___Ulcers
___Other (Please List):
_____
_____
_____
_____

Family Medical History (Check if any immediate family member has ever had any of the following):
(Mother, Father, Siblings, Grandparents)

___Alcoholism
___Asthma
___Anemia
___Arthritis
___Birth Defects
___Cancer
___Clotting Disorder
___Depression
___Diabetes
___Drug Abuse
___Early Death
___Epilepsy
___Eye Disease
___Heart Attack
___High Blood Pressure
___High Cholesterol
___Kidney Disease
___Liver Disease
___Osteoporosis
___Seizure Disorder
___Stroke
___Thyroid Disease
___Other (Please List):
_____
_____
_____
_____
_____
_____

Operations and/ or Hospitalizations:

Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

Social History:

___Alcohol Use
___Caffeine Use
___Exercise
___Recreational Drug Use
___Sexually Active
___Tobacco Use
___Employed
___Retired
___Student

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Administrative & Financial Policy

Receipt of Privacy Practices

I acknowledge that I have received or been allowed to view a copy of Community Family Medical's Notice of Privacy Practices as required by HIPAA. This notice describes how Community Family Medical may use and disclose my protected health information, certain restrictions on the use and disclosure of my health care information, and rights I may have regarding my protected health information. Initial ____

Consent to Treatment

I consent to any and all reasonably necessary examinations and health care procedures performed by the health care providers and/ or any of the medical staff employed by Community Family Medical, including but not limited to the administration of medication, any lab procedures, x-rays, blood draws, or any other treatments deemed reasonably necessary by the provider at the time of my examination. Initial ____

Consent to Obtain Medication History

Our system allows us to collect and review your "medication history", which is a list of prescription medicines that we or other providers have recently prescribed to you. We need to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history. I permit you to obtain my medication history from my pharmacy, my health plans, other health care providers, and the Prescription Monitoring Program (PMP). Initial ____

Personal Information Verification

It is our policy to verify your demographics and insurance information at every visit to help ensure that claims are processed timely and accurately. Although it may seem unnecessary at the time, this is extremely important to our billing process. Please bring your insurance card with you to every visit.

Initial ____

Forms and Paperwork

There is a minimum fee of $25.00 for the release of any medical records which is the responsibility of the patient to pay prior to receiving the records. A $25.00 fee will be charged for the completion of FMLA, school forms, camp forms, or any other form the provider has to complete. Payment is due when the forms are requested and there is a 48 to 72 hour allotted time for us to complete the forms. Initial ____

Financial Policy

- Payments for services are always due at the time services are rendered. Co-Pays, deductibles, coinsurances, and all non-covered services will need to be paid on the date of service, We will file your insurance, but be aware that insurance plans vary considerably and all charges not covered are your responsibility. Self-pay patients will be expected to pay in full at the time of visit.
- It is your responsibility to understand your benefits and what is covered. Some labs and screenings include but are not limited to Vision screen, Hearing screen, Rapid In-House Test, X-Ray, or ECG. These services may not be covered due to deductible, co-insurance, or simply a non-covered service. In these cases, they will be your responsibility.
- Prior balances must be paid at the time of visit. If you have an outstanding balance that you can not pay on at the time of visit, you may be rescheduled to come back when the balance can be paid.
- We accept cash, Visa, Mastercard, American Express, and Discover cards.
- **Any outstanding balance longer than 90 days will be forwarded to our collection agency. Payment arrangements can be made.**

Initial ____

Arkansas Medicaid

- We do accept Arkansas Medicaid and ARKids, however, this is at the providers' discretion. You will have to verify with Community Family Medical if we are accepting new patients at this time.
- If you have Arkansas Medicaid or ARKids, Community Family Medical requires you to contact ConnectCare to assign or change your Primary Care Provider (PCP) prior to the visit. We will provide you with the correct PCP information you will need in order to update this information with ConnectCare. Initial ____

Patient Printed Name: _____ **Date**: _____

Patient or Guardian Signature: _____

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Medication/Controlled Substance Policy

As part of your medical treatment, our providers may prescribe medications for you. It is possible to experience serious side effects of these medications if they are not managed properly. Your health and safety are very important to us at Community Family Medical, and we require you to help us make sure your treatment follows our guidelines.

Please read and acknowledge each line carefully.

- Community Family Medical may not prescribe controlled or habit-forming medications on my first visit. You must be a patient with CFM for a minimum of 30 days.
- I agree to follow the dosing schedule prescribed to me by my provider.
- I agree to NEVER share my medications with others, nor will I sell or exchange my medications for any reason.
- I understand that I am solely responsible for the safekeeping of my medications. Community Family Medical will have no obligations to replace lost or stolen prescriptions or medications.
- I agree to use only one pharmacy for my controlled medication prescriptions.
- I understand there will be no early refills of any narcotic or controlled medications.
- Medication refills will only be available during normal business hours, Monday through Friday from 8:00 am to 5:00 pm. A 48-hour notice is required for all refills. Refills can not be made after hours, on the weekend, or on holidays.
- I understand that I should not drive or operate heavy machinery while I am taking medications that may cause drowsiness or impaired cognitive functions.
- I understand that Community Family Medical reserves the right to request a urine drug screen at any time when I am prescribed controlled substances. If my screen test positive for any non-prescribed substances or negative for medications I have been prescribed, I understand that this is grounds for dismissal from Community Family Medical.
- I understand that if I have previously received narcotics/controlled substances from another provider, you are not guaranteed to receive them here.
- I understand that it is my responsibility to ensure records are received in a timely manner. Community Family Medical will send the request to the previous provider but it will fall under the patient's responsibility after that.
- I understand that refunds will not be given, under any circumstances, for visits or consultations regarding narcotics or controlled substances.
- I understand long-term pain management (chronic pain for more than 6 months) may require a referral to a pain management specialist.
- I understand that controlled medications will not have refills and I am to come in once a month for a visit to acquire a refill on any controlled substance for proper monitoring.
- I understand I may be prescribed pain medication or controlled substances short-term for acute painful injuries such as a fracture or lacerations. These medications are temporary and will not be refilled.

I hereby authorize the providers of Community Family Medical to access historical prescription drug information. No medications will be prescribed without the acceptance of this agreement.

By signing this agreement, I affirm that I have the full right and power to be bound by this agreement and that I have read, understood, and accepted these terms. I understand that I may be dismissed from Community Family Medical if I do not abide by the terms of this medication agreement.

Patient Printed Name: _____ **Date**: _____

Patient or Guardian Signature: _____

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Medical Records Release

Patient Name: _____ Date of Birth: _____
Address:_____
City:_____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____

Please release my medical records as follows:

From: _____
_____
_____

To: Community Family Medical
1139 State Hwy 77
Marion, AR 72364

Records to be released (please check all that apply):

___ All medical records
___ Annual exam
___ Labs / X-Rays
___ Medications
___ Other: _____

Conditions and Notifications

This authorization for the release of information expires 12 months from the date of the patient's signature. You may revoke this authorization at any time by informing Community Family Medical in writing at the address listed above. However, such notification will not affect any actions taken in reliance on this authorization proper to the time of receipt of the revocation. You may inspect or request a copy of the health information to be used or disclosed, consistent with federal law. This authorization is being given to Community Family Medical identified above.

Signatures

I hereby authorize the use or disclosure of personal health information as described above. I understand that I may refuse to sign this authorization, that this is voluntary, and that my health care and the payment for my health care will not be affected if I do not sign this form. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and, therefore, may be subject to re-disclosure.

Signature of Patient/Personal Representative:_____ **Date**: _____

Print Name of Patient/ Personal Representative: _____

Relationship of Representative to Patient: _____

Witnessed by: _____ **Date**: _____
(Department Representative Name)