Lawrence Family Medicine

B. Brooks Lawrence, M.D.
Janet L. Reed, P.A.-C
3650 W. College Ave Conway, AR 72034
Phone: 501-327-6900 Fax: 501-327-3690

For your convenience, please ***fill out all forms*** and present them to the front desk when you arrive for your first office visit on _____. Please arrive no later than _____.

At your appointment you will need:

- Completed Patient Paperwork
- Driver License or Photo I.D.
- All Medications in the bottle
- Insurance Card(s)

If you are not the primary insured, we will also need the primary insured's:

- Name
- Date of birth
- Social Security Number
- Address
- Telephone Number

Please note that it is the patient's responsibility to pay deductibles, co-pays and/or co-insurance **on the day of service**, and to pay any outstanding balance not paid for by insurance.

If you are unable to keep your appointment kindly give 24 hour notice. Please note that if your appointment is not canceled, you will not be permitted to schedule a second appointment time.

We look forward to seeing you.

Lawrence Family Medicine

REGISTRATION
(Please Print)

B. Brooks Lawrence, M.D., P.A.
Janet L. Reed, PA-C
3650 W. College Ave
Conway, AR 72034
Ph: 501-327-6900

Date_____

Patient Name_____Birthdate_____Age_____

Responsible party (if a minor)_____ Relationship to patient_____

Mailing Address_____

City_____ State_____ Zipcode_____

Social Security # _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Home Phone_____ Cell Phone_____

Sex ☐ M ☐ F Email Address_____

Patient Employed By_____Occupation_____

Business Address_____Business Phone_____

Do you have medical insurance? ☐ Yes ☐ No Are you a student? ☐ Full-time ☐ Part-time ☐ Not a student

Name of Primary Insurance_____

Patient ID #_____ Group #_____

Name of Primary on Insurance_____ Relationship to patient_____

Primary Insured Birthdate_____ Primary Insured Social Security #_____

Primary Insured Mailing Address_____

City_____ State_____ Zipcode_____

Name of Secondary Insurance_____

Patient ID #_____ Group#_____

In case of an emergency, who should be notified?_____Phone_____

How did you learn of this practice? _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with (name of insurance company)_____ and assign directly to Dr. Brooks Lawrence all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on my insurance submission.

*Signature of Insured/Guardian*_____ Date_____

MEDICAL AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf of Dr. Brooks Lawrence for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature request that payments be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

*Signature of Insured/Guardian*_____ Date_____

Lawrence Family Medicine

Dr. B. Brooks Lawrence, M.D. Janet L. Reed, P.A.-C

Health History

Name_____ Date_____

Age_____ Birthdate_____ Date of last physical exam_____

What is your reason for this visit?_____

SYMPTOMS Please check symptoms you have had in the last year.

General

Past/Now

__ __ Chills
__ __ Depression
__ __ Dizziness
__ __ Fainting
__ __ Fever
__ __ Forgetfulness
__ __ Headache
__ __ Loss of sleep
__ __ Loss of weight
__ __ Nervousness
__ __ Numbness
__ __ Sweats

Muscle/Joint/Bone

Pain, weakness, numbness in:

__ __ Arms
__ __ Back
__ __ Feet
__ __ Hands
__ __ Hips
__ __ Legs
__ __ Neck
__ __ Shoulders

Urinary

__ __ Blood in Urine
__ __ Frequent urination
__ __ Lack of bladder control
__ __ Painful urination

Gastrointestinal

__ __ Appetite poor
__ __ Bloating
__ __ Constipation
__ __ Diarrhea
__ __ Excessive hunger
__ __ Excessive thirst
__ __ Gas
__ __ Hemorrhoids
__ __ Indigestion
__ __ Nausea
__ __ Rectal Bleeding
__ __ Stomach pain
__ __ Vomiting
__ __ Vomiting blood

Cardiovascular

__ __ Chest pain
__ __ High blood pressure
__ __ Low blood pressure
__ __ Poor circulation
__ __ Rapid heart beat
__ __ Swelling of ankles
__ __ Varicose veins

Eye, Ear, Nose, Throat

__ __ Bleeding gums
__ __ Blurred vision
__ __ Crossed eyes
__ ___ Difficulty swallowing
__ __ Double vision
__ __ Earache
__ __ Hay fever
__ __ Hoarseness
__ __ Loss of hearing
__ __ Nosebleeds
__ __ Persistent cough
__ __ Ringing in ears
__ __ Sinus problems
__ __ Vision – flashes/halos

Skin

__ __ Bruise easily
__ __ Hives
__ __ Itching
__ __ Change in moles
__ __ Rash
__ __ Scars
__ __ Sore that won't heal

MEN ONLY

__ __ Breast lump
__ __ Erection difficulties
__ __ Lump in testicles
__ __ Penis sore/discharge

WOMEN ONLY

__ __ Abnormal pap smear
__ __ Bleeding between periods
__ __ Breast lump
__ __ Extreme menstrual pain
__ __ Hot flashes
__ __ Nipple discharge
__ __ Painful intercourse
__ __ Vaginal discharge
__ __ Other: _____

Date of last period _____
Date of last pap smear_____
Date of last mammogram_____
Are you currently or is there a chance you could be pregnant?_____
Number of children_____

ALLERGIES

Please list all allergies:

_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY

Does your parents and/or siblings have any of the following medical conditions:

_____ Arthritis
_____ Asthma, Hay fever
_____ Cancer
_____ Chemical dependency
_____ Diabetes
_____ Heart disease or Stroke
_____ High Blood Pressure
_____ Other:_____
_____
_____

MEDICAL HISTORY Please check conditions you have or have had in the past

__ AIDS __ Alcoholism __ Anemia __ Anorexia __ Appendicitis
__ Arthritis __ Asthma __ Bleeding Disorder __ Breast lump __ Bronchitis
__ Bulimia __ Cataracts __ Cancer. If so, what kind?_____
__ Chemical dependency __ Diabetes __ Chicken pox __ Emphysema
__ Epilepsy __ Glaucoma __ Goiter __ Gout __ Gonorrhea
__ Heart disease __ Hepatitis __ Hernia __ Herpes
__ HIV Positive __ High cholesterol __ Measles __ Kidney Disease
__ Migraines __ Liver Disease __ Miscarriage __ Mononucleosis __ Mumps
__ Multiple Sclerosis __ Pacemaker __ Pneumonia __ Polio
__ Prostate Problems __ Stroke

HABITS Indicate the appropriate usage of each

Alcohol __ None __ Occasional
__ Mild 2-3 drinks per week __Moderate 1-2 drinks per day __ Heavy more than 1-2 per day

Tobacco __ None __ Smokeless
__ Former smoker When did you quit smoking? _____
__ Less than 1 pack per day __ 1 pack per day __ 2 packs per day __ more than 2 packs per day

Age you began smoking_____.

What type of product do you use? __ Cigarettes __ Cigar __ e Cigarettes Other:_____

Caffeine __None__Mild 1-2 drinks per day__ Moderate 2-4 drinks per day__ Heavy more than 4 drinks per day

Drugs __ none __ marijuana __ cocaine Other:_____

Occupation What kind of work do you do and how long have you done this?

_____

Are you exposed to __ High stress __ Hazardous substances __ Heavy lifting Other_____

PHARMACY_____

SURGICAL HISTORY

Year Surgery Reason for surgery

_____
_____
_____
_____
_____

HOSPITALIZATION Please list all non-surgical hospitalization

_____
_____
_____
_____
_____

Is there any other information you feel we need to know about you?

Office Use Only:
Chart #: **Date:**

Lawrence Family Medicine
B. Brooks Lawrence, M.D.
Janet Reed, PA-C
3650 West College Avenue
Conway, AR 72034
(501) 327-6900

Specific Authorization/HIPPA

I hereby give my authorization for Lawrence Family Medicine to use or disclose my Protected Health Information to carry out treatment, payment, or any other health care operation, including but not limited to the following: lab/diagnostic results, insurance, and leaving messages on answering machines with appointment reminders/details.

I understand that my Protected Health Information is as follows:
Information that is oral or recorded in any form that relates to my past, present, or future physical or mental health condition, my past, present, or future health care treatment, or the payment of my past, present, or future health care treatment, that is or could be reasonable identify me and is transmitted in an electronic form or maintained in any form.

This Protected Health Information could include information that Lawrence Family Medicine created, received from me, received from another Health Care Provider, received from a Health Plan, Health Care Clearing House, Insurance Company, Employer or any other source, and could include demographic information about me.

I understand that Dr. Lawrence's office notes will be transcribed live through the use of a Medical Coordinator.

I give Lawrence Family Medicine authorization to use or disclose my Protected Health Information to other health care providers, group health plans, and business associates to provide for my medical care, treatment, and evaluation, the payment of my medical care, treatment and evaluation, and to provide information for utilization and quality care purposes. I understand that I have the right to request in writing to inspect and copy my Protected Health Information. There are a few exceptions to this rule. Lawrence Family Medicine must approve or deny my request within 30 days and in case of a denial, provide me an explanation for the reason. Lawrence Family Medicine may charge a reasonable fee for coping, preparation, and postage (if mailed to me), which must be prepaid. Lawrence Family Medicine may use an outside copy service.

I understand that I have the right to revoke my authorization; however, it shall not be considered revoked to the extent my Health Care Provider has relied on it. I understand that once this information has been disclosed to third parties, there may not be any safeguards to prevent the third party from further disclosing the Protected Health Information. I may revoke this authorization by contacting the Office Manager at Lawrence Family Medicine who may be reached by phone at 501-327-6900. I understand Lawrence Family Medicine can condition my treatment or evaluation on my signing this authorization.

_____Patient Name (print) _____Date of Birth

_____SSN _____Date Signed

_____X **Patient's Signature or Personal Representative of Patient (if Patient is unable to sign)**

I specifically give Lawrence Family Medicine authorization to use or disclose my Protected Health Information to the following person(s):

_____

name ***phone#*** ***relation to patient***

B. Brooks Lawrence, M.D., P.A.
Authorization for Release of Protected Health Information

B. Brooks Lawrence, M.D., P.A.
3650 W College Avenue
Conway, AR 72034

Phone: 501-327-6900
Fax: 501-327-3690

Last Name_____**First Name**_____**MI**_____

Date of birth_____ **SS#**_____

Phone Number_____ **Email**_____

I hereby authorize disclosure of my protected health information ("PHI") as relative to any and all records or claims as filed by B. Brooks Lawrence, M.D., P.A. ("BBL"), including, but not limited to, all aspects of patient care, billing, records, and compensations.

The purpose of this release of information is to facilitate patient care, charges, claims, and resolution, and all aspects of claim submission and reimbursement. I understand that my records are protected under the HIPAA/PHI regulations.

I understand that under the Federal Health Information regulations, I have the right to review amendments where appropriate.

I understand that I have the right to revoke this authorization at any time by notifying B. Brooks Lawrence, M.D., P.A., in writing except that actions taking by BBL upon the original authorization for release of PHI.

I have received a copy of the **NOTICE OF PRIVACY PRACTICES** from BBL, a copy of which is in my chart.

Release of information is to:

B. Brooks Lawrence, M.D., P.A.
3650 W College Avenue
Conway, AR 72034
Fax: 501-327-3690

Signature_____ **Date**_____

B. Brooks Lawrence, M.D., P.A.
NOTICE OF PRIVACY PRACTICES

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.

This Notice provides you with information on the steps this Clinic has taken to protect the privacy of your Protected Health Information. It also describes some of the privacy right you have and how you can exercise those rights. Please read this carefully. If you have any questions, please ask the receptionist if you can with speak Melissa at 501-327-6900, who is our Privacy Official. Our Privacy Official can answer questions you may have concerning this Notice.

Your Protected Health Information is that information that is created or received by this Clinic, transmitted by electronic form or maintained in any medium, that identifies you or could reasonably identify you, related to your past, present, or future:

1.) physical or mental health or condition;
2.) your health care treatment; or
3.) the payment of your health care services.

I. USES AND DISCLOSURES:

A. The following are examples of some of the ways the Clinic may use and disclose your Protected Health Information (PHI) based on your signing our Clinic's consent form:

1.) Treatment.

In order to adequately provide for your health care needs, your PHI will be used and disclosed within the Clinic by the Clinic's employees and independent contractors as necessary to treat, evaluate, and provide you with health care services. This may also include the need for us to obtain PHI from your previous health care providers in order for us to treat you properly.

2.) Payment.

To receive payment for our services, the Clinic will have to disclose certain PHI to your Health Plan or Insurer. This could require disclosure prior to treatment to obtain pre-certification from your Insurer to perform a procedure or it could be a post treatment disclosure to obtain payment for the services provided. Your Insurer also has a right to demand access to your records to determine eligibility for making pre-existing condition determinations or for conducting quality control inspections. PHI may also be disclosed to comply with works compensation laws and similar programs.

3.) Clinic Operations.

To ensure the proper functioning of our clinic, it may be necessary from time to time that certain PHI be used and disclosed. For example, we may use a sign-in sheet at the front desk to keep track of which patients have arrived. We may call out your name when it is time for you to come back to an exam room. Our employees and independent contractors may have to access our medical records for certain business operations. Our clinic may allow high school, college, or medical school “shadow” students in the clinic, and they may be exposed to certain PHI.

4.) Referrals.

In order to effectively refer you to another physician, we will have to release certain PHI to that physician to assist that physician in your treatment and to make the necessary appointment.

5.) Consultations.

There may be occasions where the Clinic may desire to consult another professional about your treatment to get a second opinion . In those situations, the Clinic will always attempt to maintain your privacy to the extent possible, recognizing that it may not always be an option.

6.) Business Associates.

As part of our business operations we have to enter into agreements with third parties to assist us. These third parties can be accountants, computer consultants, transcriptionists, etc. These third parties may have to access certain PHI. Prior to any of our Business Associates having access to PHI, they will sign an agreement that requires them to have procedures in place to protect the privacy of your PHI.

B. The following are examples of some of the ways the Clinic may use and disclose your PHI based on your opportunity to orally assent or object:

1.) Family members of Individuals Involved in Your Care.

This Clinic may use and disclose PHI to your family members or other individuals who are involved in your care when the Clinic believes it is necessary to provider your locations, general health condition, and

in the case of your death. An example might be if you needed a ride home, we might contact a relative to provide your a ride. You may inform our Privacy Official in writing if you choose to object to this use or disclosure.

2.) Faculty Directories.

We may use PHI to maintain a listing of the name, location, general condition and religious affiliation of individuals in our facilities and disclose it to religious personnel and to others who specifically request the information by identifying the individual by name. You may inform our Privacy Official in writing if you choose to object to this use or disclosure.

C. The following are examples of some of the ways the Clinic may use and disclose your PHI without your consent, authorization or opportunity to assent or object.

1.) Legal Obligations.

This Clinic will use and disclose PHI when legally required. If this situations occurs, we will notify you and we will limit the PHI to the minimum necessary to comply with the law. Some examples are as follows: court orders, subpoenas, reporting suspected abuse or neglect, reporting adverse results to the Food and Drug Administration, reporting exposures to communicable diseases, certain criminal activity, and military activity.

2.) Inmates.

If you are an inmate, this Clinic may use or disclose PHI to the facility and correctional officers when appropriate.

3.) Emergencies.

In an emergency treatment situation, our Clinic may use or disclose PHI. Our Clinic's health care professional will obtain your consent as soon as practicable following the emergency.

4.) Communication Barrier.

If there is a substantial communication barrier, this Clinic may use or disclose PHI for treatment, payment, or health care operations when circumstances would infer consent.

D. The following are examples of some of the ways the Clinic may use and disclose your PHI based on your signing our Clinic's Authorization form:

Other uses and disclosures of your Protected Health Information that do not fit into one of the above categories shall only be allowed upon your signing on of our Clinic's specific authorization forms. An examples of when this may be necessary if you would want our Clinic to release your medical records to your employer. You would need to come in and complete a specific authorization for us to disclose your PHI to your employer, unless of course your employer is your heath insurer. If your employer is your private health insurer, then it would have access to your medical records through your consent form.

You have the right to revoke any authorization, however, the revocation will not be effective to the extent the Clinic has relied on it.

II. RIGHTS:

A. Right to Request a Restriction of Uses and Disclosures.

You have the right to notify our Privacy Official in writing that you request a restriction on our use and disclosure of your Protected Health Information. Our clinic does not have to grant your request and we can condition treatment on your willingness to consent to our uses and disclosure of your Protected Health Information. We will notify you in writing whether we will grant or deny your request. If you request is granted, we may choose, at a later date, to deny to continue the restriction and, if so, we will notify you in writing of that decision.

B. Right to Request Confidential Communications.

You have the right to submit in writing a request that all our communications with you concerning your Protected Health Information be confidential. These request must be reasonable and you must provide reasonable accommodations for us to contact you for payment along with some reasonable method for us to contact you. We cannot ask you the reason for such a request.

C. Right to Inspect and Copy.

You have the right to request in writing to inspect and copy your Protected Health Information. There are a few exceptions to this rule. We must approve or deny your request within 30 days and in the case of a denial, provide you an explanation of the reason. We will charge a reasonable fee for copying, preparation and postage (if mailed to you), which must be prepaid.

D. Right to Amend.

You have the right to request in writing that we amend your Protected Health Information that we created unless the information is accurate and complete. If you make such a written request, we will act on your request and respond in writing within 60 days.

E. Right to Receive an Accounting.
You have the right to request in writing that we provide you with an accounting of our disclosures of your Protected Health Information. Standard disclosures are not included in the accounting. Examples of standard disclosures would be disclosures to you, for treatment, payment and health care operations. The first accounting in the 12 month period is free. There is a $25.00 charge for the second accounting in the same 12 month period.

F. Right to Receive Copy of Notice
You have the right to receive a paper copy of our Notice Privacy Practices. You may pick one up in our waiting room.

G. Right to File a Complaint.
The law requires us to comply with HIPAA and our Notice of Privacy Practices. If you feel we are not in compliance, you have the right to file an anonymous compliant with our office. You can file a compliant by notifying our Privacy Official in writing. We will not retaliate in any manner due to a compliant. We value your opinion. You also have a right to file a compliant with the Secretary of the Department of Health and Human Services, who is charged with enforcement of this regulation.

III. DISCLOSURE STATEMENT.

A. This Clinic intends to use and disclose Protected Health Information in the additional following ways, on which treatment is conditions:

1.) To have you sign in on a sign in sheet;
2.) To allow our staff to call out your name when it is time for you to come back to an exam, treatment, or consultation;
3.) To send out reminders of appointments;
4.) To provide alternative treatment information;
5.) To leave messages on answering machines with appointment reminders; and
6.) To contact you at the phone numbers you provide and leave messages to reschedule appointments or to leave lab results.

B. The Law requires this Clinic to have privacy protections for Protected Health Information and to give you Notice of its legal responsibilities to individuals.

C. This Clinic has to follow the terms and conditions contained in its Notice of Privacy Practices.

D. The Clinic retains the right to make retroactive changes to its Notice of Privacy Practices. This means that if the Clinic changes its Notice of Privacy Practices and thus changes its Privacy Practices and Procedures it can and will apply those changes if it chose and states so in the Notice.

E. Any individual who would like a copy of any revised Notice of Privacy Practices shall submit such a request in writing to the Privacy Official whose name is listed on the first page of this Notice.

F. This Notice is effective this the _____ day of _____ 20 _____.**(today's date)**

_____ _____
Patient **Date**

_____ _____
Personal Representative **Date**

Lawrence Family Medicine

B. Brooks Lawrence, M.D. Janet L. Reed, P.A.-C
3650 W. College Ave Conway, AR 72034

- **No Show Appointments**

Each time a patient misses an appointment, without giving proper notice, another patient is prevented from receiving care. Therefore, Lawrence Family Medicine reserves the right to charge a fee of $25 for all missed appointments. A missed appointment will be considered a no show if not canceled with a 24 hour notice. 'No Show' fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment.

By signing below, you acknowledge that you have received this notice and understand this policy.

- **Waiver for costs related to Blood Work & Immunizations**

I understand and acknowledge that if my insurance company does not cover the cost of any and all lab work or immunizations, I will be billed. These costs could include some or all of the following:

Basic Metabolic Panel	$18.00	Complete Blood Count	$17.00
Liver Panel	$18.00	Lipid Panel	$27.00
Thyroid Panel	$36.00	Vitamin D	$65.00
Testosterone	$55.00	Hemoglobin A1C	$21.00
Gardasil	$178.00	Meningococcal	$159.00
T-Dap	$71.00	Varivax	$130.00

By signing below, I agree to pay for any costs not covered by my insurance.

- **Waiver for costs related to Routine Physicals**

Due to the recent health care reform act, certain tests are no longer covered under routine wellness physicals. If these costs are not covered by my policy, I agree to pay the costs. These costs could include some or all of the following:

EKG	$29.00	Chest x-ray	$48.00

By signing below, I agree to pay for these or any other tests which Dr. Lawrence orders on my behalf. Furthermore, I understand that should I discuss anything outside of routine wellness that I can be charged for an office visit in addition to a wellness visit.

- **Chronic Care Management – Medicare patients only**

Patients with two or more chronic conditions may benefit from a new program that Lawrence Family Medicine is now offering to all Medicare patients. We help coordinate your visits with other doctors, lab, radiology, and other testing to provide you with a comprehensive care plan. Medicare allows us to bill for these services during any month that we have provided at least 20 minutes of non-face-to-face care of you and your conditions. You must provide your consent to participate once a year.

Dr. B. Brooks Lawrence and his staff at Lawrence Family Medicine will talk to you or handle issues related to your care, but please know that Dr. Lawrence will supervise all care provided by his staff.

You agree and consent to the following:

- As needed, we will share your health information electronically with others involved in your care. Please rest assured that we continue to comply with all laws related to the privacy and security of your protected health information.
- We will bill Medicare for this chronic care management for you once a month. The fee for this service allowed by Medicare is $42.60 You will not be billed for this service. Our office will have a record of our time spent managing your care if you ever have a question about what we did each month.
- Only one physician can bill for this service for you. Therefore, if another one of your physicians has offered to provide this service, you will have to choose which physician is best able to treat you and all of your conditions. Please let your physician or our staff know if you have entered into a similar agreement with another physician/practice. You have a right to:

  A comprehensive Care Plan from our practice to help you understand how to care for your conditions so that you can be as healthy as possible.

  Discontinue this service at any time for any reason. Because your signature if required to end your chronic care management services, please ask any of our staff members for the CCM termination form.

  24x7 access to medical records

Our goal is to provide you with the best care possible, to keep you out of the hospital, and to minimize costs and inconvenience to you due to unnecessary visits to doctors, emergency rooms, labs, or hospitals. We know your time and your health is valuable and we hope that you will consider participation in the program with our practice.

By signing below, I agree to participate in the Chronic Care Management program.

Signature_____ ***Date***_____