SouthPoint

613 Thompson Ave
El Dorado, AR 71730
Phone: (870) 881-8558
Fax: (870) 881-8568

Patient Registration

Date: _____

Last Name: _____ First Name: _____

Street Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number: _____

Race: _____ Primary Care Physician: _____

Are you currently employed? _____ If Yes, where? _____

Home Phone No.: _____ Cell Phone Number: _____

Patient Email Address: _____

Insurance Information

Primary Insurance Company: _____

ID Number: _____ Group Number: _____

Subscriber's Name: _____ Social Security Number: _____

Subscriber's Date of Birth: _____

Secondary Insurance Company: _____

ID Number: _____ Group Number: _____

Subscriber's Name: _____ Social Security Number: _____

Subscriber's Date of Birth: _____

How did you hear about us? (Circle one)

Friend or Relative Referring Physician Former Patient Advertisement Other

South Point

Medical History and Intake Form

Past Medical History: ***(please circle all that apply)***

- Anxiety
- Arthritis
- Asthma
- Atrial fibrillation
- Bone Marrow Transplantation
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD
- Hearing Loss
- Hepatitis
- High Blood pressure
- HIV/ AIDS
- High Cholesterol
- Thyroid Problems
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke

Other _____

Past Surgical History: ***(please circle all that apply)***

- Appendix Removed
- Bladder Removed
- Mastectomy (Right, Left, Bilateral)
- Lumpectomy (Right, Left, Bilateral)
- Breast Biopsy (Right, Left, Bilateral)
- Breast Reduction
- Breast Implants
- Colectomy: Colon Cancer Resection
- Colectomy: Diverticulitis
- Colectomy: IBD
- Gallbladder Removed
- Coronary Artery Bypass
- Mechanical Valve Replacement
- Biological Valve Replacement
- Heart Transplant
- Joint Replacement, Knee (Right, Left, Bilateral)
- Joint Replacement, Hip (Right, Left, Bilateral)
- Kidney Biopsy (Nephrectomy)
- Kidney Removed (Right, Left)
- Kidney Stone Removal
- Kidney Transplant
- Ovaries Removed: Endometriosis
- Ovaries Removed: Cyst
- Ovaries Removed: Ovarian Cancer
- Prostate Removed: Prostate Cancer
- Prostate Biopsy
- TURP (Prostate Removal)
- Spleen Removed
- Testicles Removed (Right, Left, Bilateral)
- Hysterectomy: Fibroids
- Hysterectomy: Uterine Cancer

Other _____

Skin Disease History: ***(please circle all that apply)***

- Acne
- Actinic Keratoses
- Asthma
- Basal Cell Skin Cancer
- Blistering Sunburns
- Dry Skin
- Eczema
- Flaking or Itchy Scalp
- Hay Fever/ Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Squamous Cell Skin Cancer

Other _____

Do you wear Sunscreen? Yes No If yes, what SPF?_____
Do you tan in a tanning salon? Yes No
Do you have a family history of Melanoma? Yes No
If yes, which relative(s)?_____

Medications: ***(Please enter all current medications)***

_____
_____
_____
_____

Allergies: ***(Please enter all allergies)***

_____
_____
_____
_____

Social History: ***(Please circle all that apply)***

Cigarette Smoking:

- Currently Smokes
- Has smoked in the past
- Never smoked
- Former Smoker

Alcohol Use:

- EtOH- None
- EtOH- less than 1 drink per day
- EtOH -1-2 drinks per day
- EtOH -3 or more drinks per day

Family History ***(Only first degree relatives)***

_____
_____
_____
_____

Preferred Language: _____

Race:_____ **Ethnic Group**:_____

Preferred Pharmacy Name: _____

ALERTS: ***(please circle all that apply)***

- Allergy to Adhesive
- Allergy to lidocaine
- Allergy to topical antibiotics
- Artificial heart valve
- Artificial joint replacement
- Blood thinners
- Defibrillator
- MRSA
- Pacemaker
- Require antibiotics prior to a surgical procedure
- Rapid heart beat with epinephrine
- Are you pregnant or currently trying to become pregnant?

Patient's Name: _____ Date: _____

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Financial Policy

South Point Medical is committed to providing our patients with premier medical care while also minimizing healthcare costs. The charges for the services we provide are reflective of the usual and customary charges for our area. The following policy statement and financial agreement outlines the Patient's and the Practice's financial responsibilities concerning payment for services:

South Point Medical will file insurance claims for our services with the patient's primary and secondary insurance carrier if applicable. Patients are required to provide proof of insurance prior to their scheduled appointments and all insurance must be verified by South Point Medical prior to the rendering of any services. Once insurance is verified, the patient will be responsible for paying any unmet annual deductibles, co-pays and estimated co-insurance prior to or immediately after receiving any services during checkout from an appointment. Patients or their Guarantors should know and understand that insurance benefits given to us by your insurance carrier(s) are not a guarantee of payment and actual payment will be determined once the claim is received by the insurance carrier(s). All charges that are not covered or paid by the insurance carrier(s) will be the responsibility of the Patient/Guarantor.

Payment is due and payable the same day that services are rendered. Any funds collected for the patient's appointment/procedure are only an estimate of the patient's portion of the costs and are not the final total a Patient or Guarantor may be responsible for and owe. *Please acknowledge this notification by initialing here:* _____

Our staff at South Point Medical will work diligently with your insurance carrier(s) to maximize all of your insurance benefits and reduce any unnecessary out of pocket costs to our patients. The staff will assist you with any insurance questions or concerns but ultimately the insurance contract is between you and your carrier(s).

South Point Medical prefers check or cash for balances due but we will also accept Visa or MasterCard credit/debit cards. Any returned check will be billed at the face value plus the maximum amount allowed under State law. Please note that our office will not accept post-dated or counter checks.

Any balance due will be billed and is due in full upon receipt. If a balance extends beyond 90 days the account will be put in collections. The Patient/Guarantor will be responsible for any additional costs incurred by South Point Medical once the account goes into collections. These additional costs include, but are not limited to: 2.0% per month interest on unpaid balances, postage costs, collection fees, legal fees and court costs.

Any lab work required as a result of your treatment that is not performed by our office will be billed separately by an independent outside lab. Your insurance, if applicable, will be billed for these services by the independent lab but you may be responsible for all or part of those costs separate from your financial responsibility with our office. *Please acknowledge this notification by initialing here:* _____

All requests for forms that are not required to complete treatment such as disability forms, FMLA or other forms will be charged a $15.00 administrative fee payable in advance. These fees are not covered by insurance.

Please sign below to indicate that you, as the Patient or Guarantor, have read, understand and will comply with the Practice's financial policies and your obligations as indicated above.

We appreciate your understanding and compliance with this policy.

_____	_____
Patient or Guarantor (printed name)	Patient or Guarantor (signature)
_____	_____
Date	Witnessed by (signature)

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, South Point Medical may use and disclose protected health information (PHI), about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the South Point Medical's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. South Point Medical reserves the right to revise its Notice of Privacy Practices as needed. The current version of the Notice of Privacy Practices may be obtained by forwarding a written request to South Point Medical marked to the attention of the Office Manager at the address indicated above.

With my consent, South Point Medical may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist South Point Medical in carrying out TPO, such as appointment reminders and patient billing statements.

By signing this form, I am consenting to South Point Medical use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that South Point Medical has already made disclosures in reliance upon my prior consent.

Additionally, I hereby authorize South Point Medical to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance carrier(s)/ company(s); and thereby authorize payment of insurance benefits directly to South Point Medical for any services rendered that are not directly paid for by me.

I understand that I am fully responsible for all charges incurred for the diagnosis and treatment provided by South Point Medical to me. Failure to sign this release will make all estimated insurance benefits due and payable before services are rendered by South Point Medical.

If I do not sign this consent, I understand that South Point Medical may decline to provide treatment.

_____ _____

Full S ignature of Patient or Patient's Legal Guardian Patient's Date of Birth

_____ _____

Printed Patient or Legal Guardian's Name Date

For Office Use only:

MR#1 Date: 12/2017 Staff Member Initials Sending:

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PATIENT AUTHORIZATION TO SHARE MEDICAL INFORMATION

The Staff of South Point Medical take the confidentiality of your medical information very seriously. We will not and cannot release any medical information to anyone other than yourself and those members of our Staff that have a valid need to know without your written authorization.

By designation and signature below, you authorize the Staff of South Point Medical to share your medical information with the following individuals in the event that you are unable to receive phone calls or have another adult that assists with or coordinates your medical care. Do not designate your Doctor.

As part of South Point Medical ***Notice of Privacy Practices*** we will not leave any health related information with any other person(s) unless you specifically authorize it.

Patient Name (please print): _____

_____ I do **NOT** authorize anyone to receive information regarding my medical care.

_____ I authorize my Provider and Staff of South Point Medical to speak with:

Name	Relation	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Alternate means of contacting me include:

My answering machine/ voicemail/ pager: _____ My Fax: _____

My email: _____ Other: _____

This authorization will remain in effect unless changed or revoked by me while I am a patient of South Point Medical. It is my responsibility to notify this office of any changes in writing or complete a new form.

Any questions concerning this form should be directed to the South Point Medical Practice Administrator at the address or phone number listed above.

By my signature, I agree to the authorizations provided on this form.

_____ _____

Full Signature of Patient or Patient's Legal Guardian — Patient's Date of Birth

_____ _____

Printed Patient or Legal Guardian's Name — Date

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MISSED APPOINTMENT POLICY

South Point Medical asks that you notify our office at least 24 hours in advance if you are unable to keep your appointment. Your advanced notification will allow us the opportunity to offer your appointment time to another patient.

Failure to notify South Point Medical of the cancellation of your appointment at least 24 hours in advance may result in a No Show fee of $45.00 which will be added to your account. This fee is not covered by insurance and is your responsibility.

Please note that we do understand that at times there are unavoidable conflicts that arise and we will certainly take this into consideration in the event that you fail to keep your scheduled appointment without notifying us at least 24 hours in advance.

Repetitive missed appointments that are incurred may result in dismissal for our Practice.

I have read and understand South Point Medical's Missed Appointment Policy.

_____ _____ _____

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_____ _____

Printed Patient or Legal Guardian's Name | Date

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MEDICARE BENEFITS & INFORMATION RELEASE

MEDICARE Number: _____

I hereby authorize Skin Surgery Specialists, dba South Point Medical, to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from the Centers for Medicare and Medicaid Services; and thereby authorize payment of insurance benefits directly to Skin Surgery Specialists, dba South Point Medical, for any services rendered that are not directly paid for by me.

I authorize any holder of medical information about me to release to the Centers from Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Full Signature of Patient or Patient's Legal Guardian | Patient's Date of Birth

_____ _____

Printed Patient or Legal Guardian's Name | Date

INSURANCE BENEFITS & INFORMATION RELEASE

I hereby authorize Skin Surgery Specialists, dba South Point Medical, to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance carrier(s)/company (s); and thereby authorize payment of insurance benefits directly to Skin Surgery Specialists, dba South Point Medical, for any services rendered that are not directly paid for by me.

I understand that I am fully responsible for all charges incurred for the diagnosis and treatment provided by Skin Surgery Specialists, dba South Point Medical, to me. Failure to sign this release will make all estimated insurance benefits due and payable before services are rendered by Skin Surgery Specialists, dba South Point Medical.

_____ _____

Full Signature of Patient or Patient's Legal Guardian | Patient's Date of Birth

_____ _____

Printed Patient or Legal Guardian's Name | Date

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Notice of Use of Third-Party Automated Outreach

By supplying my home phone number, mobile phone number, email address and any other personal contact information, I authorize my healthcare provider to employee a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness exam, balances due, lab results, or other healthcare related function. I also authorize my healthcare provider to disclose to third-parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving of multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

I agree to opt-in per the conditions stated above.

_____ _____

Patient Printed Name Date

_____

Patient/Guarantor Signature

I do not agree to opt-in to this service. I understand that I will not receive appointment reminders or other contact from my healthcare provider through a third-party service.

_____ _____

Patient Printed Name Date

_____

Patient/Guarantor Signature