Patient Information

Name: ____
(first) (middle) (last)

Nickname:____

Marital Status: S M D W Gender: M F

Birthdate: _____________________________ Age:_________

Home Address: _____________________________________

City: _________________________ State:____ Zip:_________

Email: ____

Phone:( )____

Cell # :( )____

Soc. Sec.#: ____

Employer Name:_____________________________________

Employer Phone: ( )______________________________

Responsible Party Information

Name: ____
(first) (middle) (last)

Marital Status: S M D W Gender: M F

Relationship to Patient: _________________________________

Address: ____

City: ________________________ State:____ Zip:_________

Email: ____

Phone:( )____

Soc. Sec.#: ___________________ DL# _________________

Date of Birth: _______________________________________

If patient is a child, please complete the following:

Mother **Guardian** **Stepmother**

Name: ____

Address: ____

City: ________________________ State:____ Zip:_________

Phone: ( )____

Employer Name: _____________________________________

Occupation: ____

Employer Phone: ( )_______________________________

Soc. Sec.#: ___________________ DL# _________________

Date of Birth: _______________________________________

Father **Guardian** **Stepfather**

Name: ____

Address: ____

City: ________________________ State:____ Zip:_________

Phone: ( )____

Employer Name: _____________________________________

Occupation: ____

Employer Phone: ( )_______________________________

Soc. Sec.#: ___________________ DL# _________________

Date of Birth: _______________________________________

Additional Patient Information

***Patient's Race (check one):**

☐ American Indian / Alaska Native ☐ Asian
☐ Black / African American ☐ White
☐ Native Hawaiian / Other Pacific Islander ☐ Other
☐ Declined

***Patient's Ethnicity (check one):**

☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Declined

***Patient's Preferred Language (check one):**

☐ English ☐ Spanish ☐ French
☐ Arabic ☐ Chinese ☐ German
☐ Japanese ☐ Russian ☐ Other ________________

**The collection of this information is legal and authorized under Title VI of the Civil Rights Act of 1964. The purpose of gathering this information is to improve the overall quality of healthcare offered. The information gathered is helpful in measuring trends, identifying disparity gaps in healthcare, and implementing targeted intervention toward specific populations that may be at a higher risk for certain illnesses. This information will never be used to profile patients or discriminate against patients in any way.*

Primary Insurance

Insurance Name: _____________________________________

Insurance Address: ___________________________________

City: _________________________ State:____ Zip:_________

Phone: ( )____

Effective Date: ______________________________________

Policy #: ____

Group #: ____

Insured Name: ______________________________________

Insured DOB: _______________________________________

Relationship to Patient: _______________________________

Insured Employer: ___________________________________

Secondary Insurance

Insurance Name: _____________________________________

Insurance Address: ___________________________________

City: _________________________ State:____ Zip:_________

Phone: ( )____

Effective Date: ______________________________________

Policy #: ____

Group #: ____

Insured Name: ______________________________________

Insured DOB: _______________________________________

Relationship to Patient: _______________________________

Insured Employer: ___________________________________

Authorization and Release

I authorize ***Main Street Medical Clinic, P.A.*** to release any information including the records of any treatment or examination rendered during the period of such care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to ***Main Street Medical Clinic, P.A.*** benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf for myself or my dependents.

____

Signature of Patient or Parent or Guardian of Minor Child

____

Date

Patient Name (Printed):________________________________ **Date of Birth:** _____________________

Request for Confidential Communications Regarding Medical Information:

I request that Main Street Medical Clinic communicate with me confidentially about medical matters in the following manner:

Patient's Preferred Method of Contact:

☐ Phone# _________________

☐ Email** ____

☐ Mail

Patient's Preferred Reminder Method:

☐ Phone# _________________ ☐ Cell# _________________ ☐ Work# ______________

☐ Email** ____

☐ Mail

***Our office does not currently have the ability to send secure, HIPAA-compliant email. If you select this option, you will receive an email with instructions to sign up for our patient portal, which you can use to communicate with our office securely.*

Designation of Certain Relatives, Close Friends and Other Caregivers as my Personal Representative:

I agree that the Main Street Medical Clinic may disclose certain information about my health care to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, Main Street Medical Clinic will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. These designated persons are listed below (Please note: If you want to allow us to disclose PHI to your spouse, his/her name MUST be listed):

Name: ____ Relationship:__________________________________

Name: ____ Relationship:__________________________________

Name: ____ Relationship:__________________________________

Name: ____ Relationship:__________________________________

The following person(s) <u>are not authorized</u> to receive my Patient Health Information (PHI):

Name: ____ Relationship:__________________________________

Name: ____ Relationship:__________________________________

Name: ____ Relationship:__________________________________

Name: ____ Relationship:__________________________________

__________________________________ _____________ _____________________

Signature of Patient or Legal Representative ***Date*** ***Relationship to Patient***

Patient Name (Printed):________________________________ Date of Birth: ____________________

Patient Acknowledgement of Receipt of Notice of Privacy Practices

A copy of our current Notice of Privacy Practices is provided to you as a new patient. Copies are also available at the front desk and on our website. If you have any questions regarding the information in Main Street Medical Clinic's Notice of Privacy Practices, please do not hesitate to contact a clinic representative or the Main Street Medical Clinic Patient Privacy Officer as indicated on the Notice.

Patient Acknowledgement of Receipt of Financial Policy

A copy of our current Financial Policy is provided to you as a new patient. Copies are also available at the front desk and on our website. If you have any questions regarding our Financial Policy, please contact our billing office at (501) 315-0059.

I have received a of the clinic's Notice of Privacy Practices. I have also received a copy of the Financial Policy and understand the terms contained within.

________________________________	____________	____________________
Signature of Patient or Legal Representative	***Date***	***Relationship to Patient***

Consent to Obtain Medication History from Pharmacies through e-Prescribing:

I hereby give my consent to Main Street Medical Clinic, including its licensed practitioners and employees, to access, use and disclose my protected health information to any pharmacies I currently use or will use in the future for the purpose of transmitting prescriptions to them for my treatment. I consent to the disclosure of my prescription medication information by any provider, mental health provider, pharmacy, insurer or prescription benefits manager, specifically including any state or federal health program to Main Street Medical Clinic and pharmacies for the purpose of my treatment. My consent includes the re-disclosure of protected health information maintained by a drug or alcohol treatment program.

________________________________	____________	____________________
Signature of Patient or Legal Representative	***Date***	***Relationship to Patient***

Access to Patient Portal

I understand that access to the Patient Portal is voluntary and acknowledge that I have read and fully understand the terms contained in the Patient Portal information sheet provided to me and understand that there are confidentiality risks associated with any type of online communication, including Main Street Medical Clinic's Patient Portal.

________________________________	____________	____________________
Signature of Patient or Legal Representative	***Date***	***Relationship to Patient***

Patient Name: ______________________ **Date of Birth:** ______________

Medical History

Condition		Details/Describe
ADD/ADHD	__ No __ Yes	______________
Anemia	__ No __ Yes	______________
Arthritis	__ No __ Yes	______________
Asthma	__ No __ Yes	______________
Blood Disorder/HIV	__ No __ Yes	______________
Cancer	__ No __ Yes	Type: __________
Depression	__ No __ Yes	______________
Diabetes	__ No __ Yes	______________
Emphysema	__ No __ Yes	______________
Heart Disease	__ No __ Yes	______________
Hepatitis	__ No __ Yes	______________
High Blood Pressure	__ No __ Yes	______________
High Cholesterol	__ No __ Yes	______________
Kidney Disease	__ No __ Yes	______________
Lung Disease	__ No __ Yes	______________
Migraines	__ No __ Yes	______________
Prostate Problems	__ No __ Yes	______________
Seizure	__ No __ Yes	______________
Skin Cancer	__ No __ Yes	______________
Stroke	__ No __ Yes	______________
Thyroid Disease	__ No __ Yes	______________
Ulcers	__ No __ Yes	______________

Other ______________________________

Other ______________________________

Other ______________________________

Other ______________________________

Other ______________________________

Other ______________________________

Are you currently under the care of any other physicians? Please list:

____

____

____

____

Previous Surgeries: **Date:**

Previous Surgeries	Date

Medications: **Dose:**

Medications	Dose

Preferred Pharmacy(ies):

____

____

Allergies:

______________ ______________

______________ ______________

______________ ______________

______________ ______________

Pediatric History (for patients under 18 years old)

Which pregnancy was this child? ______________

What was the mother's age at birth? ______________

What was the birth weight? ______________

☐ Vaginal ☐ Caesarean ______________

# of days baby stayed in hospital after birth ______________

Hospital where child was born ______________

Are your child's immunizations up to date? ______________

History of chickenpox? ☐ No ☐ Yes Date: ______________

Is your child regularly exposed to second-hand smoke? ☐ No ☐ Yes

Please list names of others in the household:

Name:	*DOB:*	*Relationship:*

Patient Name: ________________________________ **Date of Birth:** ____________________

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Place of Employment/Occupation: ____

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Tobacco: ☐ Never

☐ Cigarettes ☐ Previously, but quit (date) __________ ☐ Currently smoke _____ packs/day

☐ Cigars ☐ Previously, but quit (date) __________ ☐ Currently smoke _____ /day

☐ Smokeless Tobacco ☐ Previously, but quit (date) __________ ☐ Currently use________ times/day

Use of Caffeine: ☐ Never ☐ Rarely ☐ Moderate – servings per day ____________

Use of Drugs: ☐ Never ☐ Yes-Type/Frequency: ____

Family History

Have any of your blood relatives had the following?

Please check:

	Father	Mother	Brother	Sister	Paternal Grand-father	Paternal Grand-mother	Maternal Grand-father	Maternal Grand-mother
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Cancer (list type):								
____________________	☐	☐	☐	☐	☐	☐	☐	☐
____________________	☐	☐	☐	☐	☐	☐	☐	☐
____________________	☐	☐	☐	☐	☐	☐	☐	☐
Other:								
____________________	☐	☐	☐	☐	☐	☐	☐	☐
____________________	☐	☐	☐	☐	☐	☐	☐	☐
____________________	☐	☐	☐	☐	☐	☐	☐	☐

Please list any other information you would like the physician to know:

____

____

____

____

____

Physician Signature ______________________________ ***Date*** ____________________

REVIEW OF SYSTEMS

Patient Name: ____ **Date of Birth** _______________________

Constitutional Symptoms:	Please circle	
Fever	No	Yes
Headaches	No	Yes
Fatigue	No	Yes
Recent weight change	No	Yes
Eyes:		
Blurred or double vision	No	Yes
Wear contacts/glasses	No	Yes
Eye disease or injury	No	Yes
Ears/Nose/Throat:		
Swollen glands in neck	No	Yes
Chronic sinus problems	No	Yes
Earaches or drainage	No	Yes
Sore throat or voice change	No	Yes
Cardiovascular:		
Chest pain	No	Yes
Swelling of feet, ankles, or hands	No	Yes
Shortness of breath while walking or lying flat	No	Yes
Heart problems	No	Yes
Respiratory:		
Chronic cough	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes
Gastrointestinal:		
Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain	No	Yes
Genitourinary:		
Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of strain	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Pain with periods	No	Yes
Irregular periods	No	Yes
Female:		
Vaginal discharge	No	Yes

# of pregnancies ______________________

# of miscarriages ______________________

Date of last pap smear __________________

Musculoskeletal:	Please circle	
Joint pain	No	Yes
Back pain	No	Yes
Joint stiffness or swelling	No	Yes
Difficulty in walking	No	Yes
Muscle pain or cramps	No	Yes
Integumentary:		
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Breast pain	No	Yes
Breast discharge	No	Yes
Breast lump	No	Yes
Varicose Veins	No	Yes
Neurological:		
Head injury	No	Yes
Paralysis	No	Yes
Tremors	No	Yes
Numbness or tingling	No	Yes
Convulsions or seizures	No	Yes
Psychiatric:		
Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes
Endocrine:		
Glandular or hormone problem	No	Yes
Excessive thirst or urination	No	Yes
Skin becoming drier	No	Yes
Heat or cold intolerance	No	Yes
Hematologic/Lymphatic:		
Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Enlarged glands	No	Yes

Allergic/Immunologic:

Food allergies:

____

____

Drug allergies:

____

____

____

____

____
Patient Signature or Signature of Parent/Legal Guardian

____
Date Signed

_________________________________ _______________
Physician Signature ***Date Signed***

Effective Date of this Notice: 08/13/2013

Main Street Medical Clinic, P.A. 722 N Main St, Benton, AR 72015 Phone (501) 315-0059 Fax (501) 315-0083

Internal Medicine & Pediatrics www.mainstreetmedicalclinic.com

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR PROTECTED HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in regards to your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Privacy Officer Phone (501) 315-0059
Main Street Medical Clinic
722 North Main Street
Benton, AR 72015

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your PHI:

1. Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when Internal or Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs.

13. Marketing and Disclosures That Constitute a Sale of PHI. Authorization from the patient is required for uses and disclosures of PHI for marketing purposes or disclosures that constitute the sale of PHI.

14. Other Uses and Disclosures Not Described in This Notice. Other uses and disclosures not described in this notice will be made only with authorization from the individual.

E. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Privacy Officer specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions.

1) You have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Privacy Officer. Your request must describe in a clear and concise fashion:
   a) the information you wish restricted;
   b) whether you are requesting to limit our practice's use, disclosure or both; and
   c) to whom you want the limits to apply.
2) You have the right to request a restriction in our use or disclosure of your PHI to a health plan if:
   a) The disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and
   b) The PHI pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, **has paid the covered entity in full**.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Privacy Officer in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. Examples include when the doctor shares information with the nurse or the billing department uses your information to file your insurance claim. Also, we are not required to document disclosures made pursuant to an authorization signed by you. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the Privacy Officer.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. For questions related to filing a complaint, contact our office and ask for the Privacy Officer. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

9. Rights Regarding Breach Notification. You have the right to receive notification of breaches of your unsecured PHI. Our practice will notify you of breaches of your unsecured PHI in accordance with the requirements of the HIPAA Privacy Rule, the HITECH Act, and the Omnibus Rule.

If you have any questions regarding this notice or our health information privacy policies, please contact the Privacy Officer.

FINANCIAL POLICY

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable deductible amounts, co-insurance and co-payments for participating insurance companies. ***Co-payments for children are due at time of service regardless of who brings the child in.*** Please make arrangements to send payment with the person bringing your child in. You may be required to pay your co-payment before your visit.

Main Street Medical Clinic accepts cash, personal checks (in-state only), and Visa/Mastercard/Discover credit, debit, and HRA cards. A $25 fee will be added for returned checks. If we receive a returned check for any reason, we may require cash payments for future visits.

Monthly payments on outstanding balances are required to keep the account current. Accounts over 90 days old may be forwarded to a collection agency if no payments are being received. Patients who have not made a payment on their account in the past 30 days will be required to pay before they are seen in the office again, except in the case of an emergency. We realize that people experience financial difficulty from time to time. Please contact our office if you are unable to pay your monthly payment, and we will make every effort to extend reasonable arrangements to you until the account is resolved. ***Balances carried on the account may not exceed $200. If your balance exceeds $200, please contact our office to schedule a payment plan to reduce your balance.***

Our office will periodically update our patients' personal information files. This is necessary to ensure that insurance is billed properly and statements are sent to the correct address. Please be patient if you are asked to update your files.

Insurance:
We file claims with health insurance companies as a courtesy to you. It is your responsibility to provide us with a current copy of your insurance card at the time of service. We are unable to file an insurance claim on your behalf without this information. You are expected to pay your deductible amounts, co-insurance, and co-payments at the time of service. If we have not received payment from your insurance company within 90 days of the date of service, you will be expected to pay the balance in full.

We do not file claims for Workers' Compensation or Motor Vehicle Insurance. Payment will be required at the time of service. However, we will provide you with a receipt so that you may file the claim yourself.

Refunds:
Overpayments will be refunded within 30 days of request.

Managed Care:
If you are enrolled in a managed care insurance plan (i.e., HMO, PPO), you must receive a referral from our office *before* seeing a specialist. Retroactive referrals may not be provided dependent on circumstances

Missed Appointments:
Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. Excessive abuse of scheduled appointments may result in discharge from the practice.

If you have any questions regarding our financial policy, please contact our billing office at (501) 315-0059.

PATIENT PORTAL

Our "Patient Portal" is a free webpage that uses encryption to keep messages and content secure from unauthorized persons. Secure messages and information can only be viewed by someone entering the correct username and password to log in to the Portal site.

From this portal you can:

- Request a medication refill
- See lab results
- Receive confidential messages from us
- View your medical history information for your own information or to give to another provider
- Other convenient functions that may be added from time to time

The portal is intended to provide a convenient way to correspond with our office and view your health information. It does not allow for any type of diagnosis or medical advice, and *should never be used in an emergency situation*. You can still contact our office via telephone or in person at any time.

Our office will grant access to register for the portal by providing a one-time token with instructions on how to register. Once you are registered, you can access the Patient Portal by logging in at https://www.healthportalsite.com/mainstmed.

For your ease of use and to maintain security of your medical information, you should:

- Advise us any time there is a change in your primary contact email address
- Use caution when communicating highly sensitive or personal information via Portal messages
- Always follow-up on your inquiry in person or over the phone if a portal inquiry is not responded to within a reasonable time
- Not allow anyone else to have access to your username and password
- Not store messages on your employer-provided computer
- Never use the portal for emergency needs
- If you have any questions, please refer to the help file in the Patient Portal by clicking on the question mark icon near the top right of the screen. If you still need help, please contact our office.

SHARE Patient Participation Information

What is SHARE?

Your health information today is usually sent from one provider to another by fax machine or mail. SHARE makes it possible to send your health information electronically, securely and faster.
SHARE is a way of sharing your health information statewide among your doctors, hospitals, labs, radiology centers and other health care providers.

What health information will be shared?

Lab and X-ray results, diagnoses, drug allergies, prescriptions, immunization history; medical records that are faxed or mailed can also be sent through SHARE. Sensitive information will not be included, such as adoption, mental health and substance abuse treatment records.

Why should my providers view my health records in SHARE?

It may save your life in an emergency - Through SHARE, a provider can get vital medical information to treat you in case of an emergency when you might not be able to answer questions.
It can improve your care - Health care providers need your health information to accurately diagnose and treat you.
It will save time & money- Access to medical tests and results may reduce the tests that are ordered, which can save you money.

Who can access my information?

Only health care providers participating in SHARE can access your information for treatment, coordination of care, and public health reporting. You can view participants at sharearkansas.com/directory. SHARE employees will have access for technical support.

How is my privacy protected?

Information exchanged through SHARE is protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). HIPAA regulates the use of your personal health information and requires that your information be protected

Can I opt-out of SHARE?

Participation in the Arkansas **S**tate **H**ealth **A**lliance for **R**ecords **E**xchange (SHARE) is optional. Your health information will be made available to your participating health care providers unless you OPT-OUT. If you choose to opt-out, ask your registration clerk for and complete an Opt-Out Form. You can also opt-out for your minor child (under age 18) using the same process.

Questions? If you have questions contact the registration desk.
To learn more online about SHARE, go to **SHAREarkansas.com**

Insurance & Payment
We file claims with health insurance companies as a courtesy to you. It is your responsibility to provide us with a current copy of your insurance card at the time of service. We are unable to file an insurance claim on your behalf without this information.

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable deductible amounts, co-insurance and co-payments.

Co-payments for children are due at time of service regardless of who brings the child in. Please make arrangements to send payment with the person bringing your child in.

We do not file claims for Workers' Compensation or Motor Vehicle Insurance. Payment will be required at the time of service. However, we will provide you with a receipt so that you may file the claim yourself.

If you have any questions regarding insurance or payments, please call our office during normal business hours and ask to speak to the billing department.

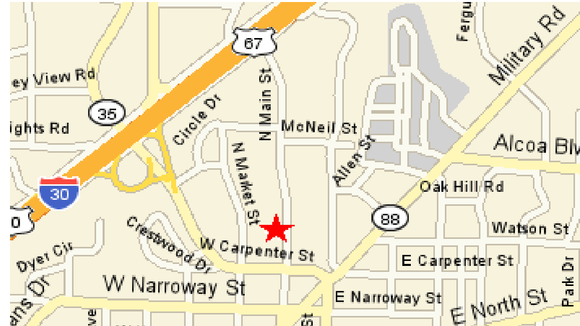
Contact Information

Office Hours

Monday - Friday, 8:00am - 5:00pm

Location

722 North Main Street
Benton, AR 72015



Telephone

(501) 315-0059

After hours, please call

(501) 778-7666

Website

www.mainstreetmedicalclinic.com

Clay Brashears, M.D.
Jim Ed Brewer, M.D.

Internal Medicine & Pediatrics

We appreciate the opportunity to serve your healthcare needs. This brochure contains information about our clinic and is provided to answer most of the questions you might have. Please contact us with any concerns or additional questions you may have.

Updated 6/24/14

Clinic Services

Our clinic specializes in health care for the entire family. Our services include the following:

- Adult & Geriatric Medicine
- Adult Wellness Exams
- Acute Illness Care
- Chronic Disease Management
- Adolescent Care
- Well-Child Care
- Pediatric Care
- Immunizations
- Laboratory
- Minor Surgery

Appointments

Please call our office to schedule appointments for your care so that we can better serve all of our patients. Walk-in patients are offered the next available appointment time. Requests for appointments received after 3:00pm may be accommodated the next day. We will do our best to accommodate your scheduling preferences; however, priority is given to those patients with acute illness or injuries. We strive to schedule routine appointments including medication follow-ups, well-child exams, and preventive care within 5 business days.

Missed Appointments:

If you will be late for your appointment, please call our office. If you are more than 15 minutes late, we may request to reschedule so that our other patients are not inconvenienced.

If you cannot keep your scheduled appointment, we request that you notify the clinic 24 hours in advance. However, please contact us as soon as possible any time you are unable to keep your appointment. Your cancellation allows us to serve patients who may not otherwise have been seen.

Phone Calls

If you call during business hours (8:00am-5:00pm, Monday-Friday) with an urgent problem or emergency, please let the receptionist know so you can be directed appropriately. Clearly state your problem, how long you've been experiencing it and any symptoms you notice.

For non-emergent calls, please note that we often cannot return calls for messages until the end of the day. Our physicians and clinic staff are serving other patients in the clinic and will call you back as soon as possible. We will attempt to call you back the same day, so please ensure that you have provided us with a correct phone number and that you are close to your phone to receive the call. When leaving a message with the front office staff, please give a detailed description of your request so that the clinic staff might handle your needs more quickly.

After Hours Phone Calls

If you have a problem after our normal business hours that cannot wait until the next business day, our clinic has a physician on call during evenings, weekends, and holidays. This physician is available for medical emergencies and problems that need immediate attention. You can reach the on-call physician by calling our **after hours number (501) 778-7666**. Please note that the on-call physician may not have access to your medical records, so they will not be able to refill your routine medications.

Prescriptions & Medications

To request prescription refills, please contact your pharmacy to send us a refill request. If you must call our office please only call once, and give your detailed request to our front office staff. We try to fill all prescription requests within 24 hours, but sometimes this is not possible because of your insurance requirements. Please begin the process of refilling your prescription at least 3 business days before you will run out of medication.

We suggest you keep an updated list of all of your current medications. If you take more than five medications, we ask that you bring in the bottles to every visit to accurately confirm your medication list in our records.

Hospital Care

If you ever require inpatient care, we will work with you to coordinate your care. Our physicians have admission privileges at Saline Memorial Hospital. Adults will be admitted to the care of a hospitalist (a physician who specializes in inpatient care). Pediatric patients will be admitted under the care of our physicians and may also be seen by other physicians in our on-call group. If it is necessary or you prefer to be admitted to another hospital, we will assist you as we are able and resume your care upon discharge. It is important that you notify our office after any inpatient stay.