

**PATIENT INFORMATION – Please Print**

Patient Name \_\_\_\_\_  
Last First Middle

Gender:  M  F Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ Apt. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Mobile \_\_\_\_\_

Misc Phone 1 \_\_\_\_\_ Misc Phone 2 \_\_\_\_\_

Preferred Contact Method: (circle one) Home Mobile Misc Phone 1 Misc Phone 2 Work Email

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Please check one:  Married  Single  Partner  Divorced  Widowed

Race:  White  African American  Asian  Native Hawaiian/Other Pacific Islander  
 Native American Indian/ Alaskan  Other Race \_\_\_\_\_

Ethnicity (Origin):  Not Hispanic or Latino  Hispanic or Latino Preferred (Primary) Language: \_\_\_\_\_

Primary Physician \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Street \_\_\_\_\_

Appointment Reminder: Please select how you would like to be notified of your appointment. You may select more than one option.  Email  Text  Phone call Message and data rates may apply for text messages. To change your preferences at anytime, you may fill out an Appointment Reminder form at the receptionist desk. You may also customize appointment reminders through your myMANA account.

Would you like to have access to your health records and communicate with your physician office online through a secure myMANA account?  Yes  No

**EMAIL AUTHORIZATION**

Email Address \_\_\_\_\_  
By providing my email address above, I hereby agree to allow MANA to contact me by email with e-newsletters, wellness reminders, health news and updates regarding health-related services provided by MANA. I understand that MANA will not share the information provided above with outside companies.

**SPOUSE or PARENT (if minor) INFORMATION**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

*Relative or Friend not in the home*

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PATIENT NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I have received a copy of the Patient Notice of Privacy Practices from Medical Associates of Northwest Arkansas.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

In the event this Acknowledgement form is being executed by a personal representative, guardian or parent, please print your name, date of birth, social security number and relationship to the patient here:

*If you would like to authorize MANA clinic to release information to a **family member, spouse, or personal representative**, please complete an **Individual Authorization Form** provided by the receptionist.*

**→ → Please complete the back page → →**

Patient Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

**PERSON RESPONSIBLE FOR PAYMENT**

My self/ My spouse (skip to the next section) OR: (List Father, Mother, Guardian or other)

Responsible Party \_\_\_\_\_ DOB \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ SS# \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**HEALTH INSURANCE INFORMATION**

*Please provide a copy of your insurance card to the receptionist.*

MEDICARE  Medicare No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Effective Date \_\_\_\_\_

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Medical Associates of Northwest Arkansas for any services furnished to me by the provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid and its agents any information needed to determine these benefits payable for related services.

**PRIMARY INSURANCE** \_\_\_\_\_

ID# \_\_\_\_\_ GP# \_\_\_\_\_ Phone# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Policy Holder:  Self  Spouse  Child  Step-Child  Other

**SECONDARY INSURANCE** \_\_\_\_\_

ID# \_\_\_\_\_ GP# \_\_\_\_\_ Phone# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Policy Holder:  Self  Spouse  Child  Step-Child  Other

**INSURANCE AUTHORIZATION & FINANCIAL AGREEMENT**

I hereby authorize Medical Associates of Northwest Arkansas (MANA) to give my insurance company or companies all information they may require concerning my case, and I hereby assign to the physician(s) all payments for medical services rendered.

I understand that I am responsible for any amount not covered by insurance. I agree to pay any co-pay and amount due at the time of service.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US?**

- |   |  |
|---|--|
| 01 <input type="checkbox"/> Recommended by a friend or family member. | 08 <input type="checkbox"/> Citiscapes Magazine                                |
| 02 <input type="checkbox"/> Clinic web site, www.mana.md              | 09 <input type="checkbox"/> Newspaper  |
| 03 <input type="checkbox"/> Other web site _____                      | 10 <input type="checkbox"/> Yellow Pages / phone directory                     |
| 04 <input type="checkbox"/> E-mail, Facebook or Twitter               | 11 <input type="checkbox"/> Received a postcard in the mail.                   |
| 05 <input type="checkbox"/> Signs or location                         | 12 <input type="checkbox"/> Referred by Doctor _____                           |
| 06 <input type="checkbox"/> Kids Directory Magazine                   | 13 <input type="checkbox"/> Found the doctor listed in my Insurance directory. |
| 07 <input type="checkbox"/> My employer                               | 14 <input type="checkbox"/> Other <i>Please specify</i> _____                  |

***Thank you for choosing a MANA Clinic.***

## Magnetic Resonance (MR) Procedure Screening Form For Patients

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_  
Last name First name Middle Initial

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Male  Female  Body Part to be Examined \_\_\_\_\_

Reason for MRI and/or Symptoms \_\_\_\_\_

Referring Physician \_\_\_\_\_

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind?  No  Yes

If yes, please indicate the date and type of surgery:

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Type of surgery \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Type of surgery \_\_\_\_\_

2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)?  No  Yes

If yes, please list:	Body part	Date	Facility
MRI	_____	____/____/____	_____
CT/CAT Scan	_____	____/____/____	_____
X-Ray	_____	____/____/____	_____
Ultrasound	_____	____/____/____	_____
Nuclear Medicine	_____	____/____/____	_____
Other	_____	____/____/____	_____

3. Have you experienced any problem related to a previous MRI examination or MR procedure?  No  Yes

If yes, please describe: \_\_\_\_\_

4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)?  No  Yes

If yes, please describe: \_\_\_\_\_

5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)?  No  Yes

If yes, please describe: \_\_\_\_\_

6. Are you allergic to any medication?  No  Yes

If yes, please list: \_\_\_\_\_

7. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination?  No  Yes

If yes, please describe \_\_\_\_\_

8. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, or seizures?

No  Yes If yes, please describe: \_\_\_\_\_

**9. For female patients:** The FDA has not established any criteria under which a pregnant woman may be scanned. Therefore, it is the policy of this facility that MR imaging NOT be routinely performed on a woman known or suspected to be pregnant.

Are you pregnant or breastfeeding?  Yes  No

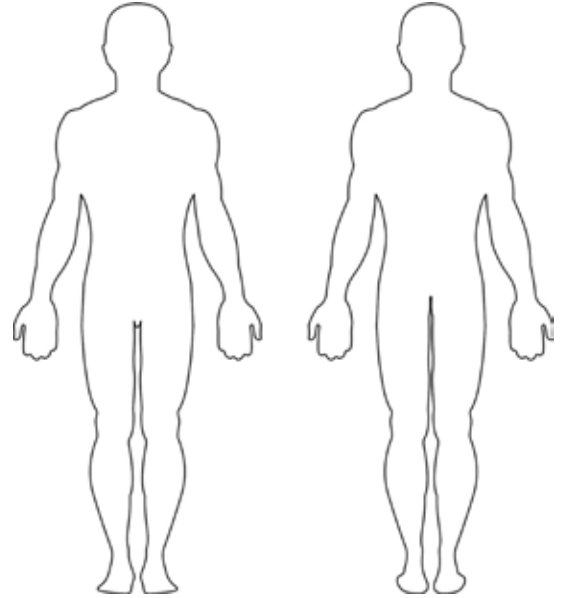


**WARNING:** Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MR system room. **The MR system magnet is ALWAYS on.**

**Please indicate if you have any of the following:**

- Yes  No Aneurysm clip(s)
- Yes  No Cardiac pacemaker
- Yes  No Implanted cardioverter defibrillator (ICD)
- Yes  No Electronic implant or device
- Yes  No Magnetically-activated implant or device
- Yes  No Neurostimulation system
- Yes  No Spinal cord stimulator
- Yes  No Internal electrodes or wires
- Yes  No Bone growth/bone fusion stimulator
- Yes  No Cochlear, otologic, or other ear implant
- Yes  No Insulin or other infusion pump
- Yes  No Implanted drug infusion device
- Yes  No Any type of prosthesis (eye, penile, etc.)
- Yes  No Heart valve prosthesis
- Yes  No Eyelid spring or wire
- Yes  No Artificial or prosthetic limb
- Yes  No Metallic stent, filter, or coil
- Yes  No Shunt (spinal or intraventricular)
- Yes  No Vascular access port and/or catheter
- Yes  No Radiation seeds or implants
- Yes  No Swan-Ganz or thermodilution catheter
- Yes  No Medication patch (Nicotine, Nitroglycerine)
- Yes  No Any metallic fragment or foreign body
- Yes  No Wire mesh implant
- Yes  No Tissue expander (e.g., breast)
- Yes  No Surgical staples, clips, or metallic sutures
- Yes  No Joint replacement (hip, knee, etc.)
- Yes  No Bone/joint pin, screw, nail, wire, plate, etc.
- Yes  No IUD, diaphragm, or pessary
- Yes  No Dentures or partial plates
- Yes  No Tattoo or permanent makeup
- Yes  No Body piercing jewelry
- Yes  No Hearing aid  
(Remove before entering MR system room)
- Yes  No Other implant \_\_\_\_\_
- Yes  No Breathing problem or motion disorder
- Yes  No Claustrophobia

Please mark on the figure below the location of any implant or metal inside of or on your body.



**IMPORTANT INSTRUCTIONS**

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

**NOTE:** You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

**Please consult the MRI Technologist if you have questions or concerns before you enter the MR Suite.**

I have read and understood and hereby consent to this MRI examination.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

I have reviewed and discussed these safety items with the above signed patient or guardian and approve this patient for magnetic resonance imaging.

Technologist Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Medical Associates of Northwest Arkansas (MANA)

# Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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.**

### Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

#### Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

#### Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

#### Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

#### Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

#### Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

#### Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

#### Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

#### File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page the next page (2) / back page.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

### Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
  - Share information in a disaster relief situation
  - Include your information in a hospital directory
- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

## Our Uses and Disclosures

### How do we typically use or share your health information?

We typically use or share your health information in the following ways.

#### Treat you

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

#### Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

#### Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

### How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

#### Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

#### Do research

We can use or share your information for health research.

#### Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

#### Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

#### Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

### Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

### Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

*We do not market or sell personal information.*

*We do not create or maintain psychotherapy notes at this practice.*

### Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/notice.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/notice.html).

### Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

### Medical Associates of Northwest Arkansas (MANA)

#### Privacy Officer:

Paula Maxwell, Chief Operating Officer

3383 N. MANA Court, Suite 201

Fayetteville, AR, 72703

Phone: (479) 571-6780

Email: [privacyofficer@mana.md](mailto:privacyofficer@mana.md)

Effective Date: September 23, 2013

## Authorization For Release of Protected Health Information

I, \_\_\_\_\_, give all physicians and professional staff employed by Medical Associates of Northwest Arkansas, P.A. permission to disclose the protected health information set forth below to the following people at the request of one or more of these individuals.

Patient name (print): \_\_\_\_\_ D.O.B. \_\_\_\_\_

Information to be released to the below referenced entity:

Complete Medical Record  or specific information: \_\_\_\_\_

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Please Print:	Name	Relationship to Patient
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I give Medical Associates of Northwest Arkansas P.A., permission to:

- Fax my child's **School Excuse** to his/her school.  
 Yes  No
- Leave a message (s) on my answering machine if they should need to remind me of an appointment, change an appointment, etc, and are unable to reach me in any other way.  
 Yes  No

In addition, I understand or acknowledge the following:

1. I understand that Medical Associates of Northwest Arkansas, P.A., will not release any information to any person(s) not listed above.
2. I have the right to revoke this Authorization at any time by giving Medical Associates of Northwest Arkansas, P.A., a written notice. I understand this does not apply to the release of PHI pursuant to my prior authorization.
3. I have received Medical Associates of Northwest Arkansas's Notice of Privacy Practices
4. My protected health information may be subject to re-disclosure by one or more of the persons named above and as such may no longer be protected by federal or state law.

This authorization shall expire on the \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ and/or the following **Event** \_\_\_\_\_

Patient Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

In the event the Authorization is being executed by a personal representative, guardian, or parent, please print your name, relationship to the patient, and basis of authorization to act on the patient's behalf.

Print name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

What is your authorization to act on the patient's behalf? \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

