



**Internal Use Only**

**PATIENT REGISTRATION**

*www.mana.md*

**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 \_\_\_\_\_

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..

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**

Emergency Contact \_\_\_\_\_ *Relative or Friend not in the home* 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.**

# Neurology Health Questionnaire

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

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

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

## Medication List:

Prescription and Non-Prescription Name	Strength	Frequency

## Medication Allergies:

Medication	Allergic Reaction:

Are you right or left handed?  Right  Left  Both

## About Your Illness

What is the main problem? \_\_\_\_\_

When did it begin? \_\_\_\_\_ What caused it? \_\_\_\_\_

How long does it last? \_\_\_\_\_

What brings it on? \_\_\_\_\_

What makes it better (include medications if any) ? \_\_\_\_\_

What makes it worse? \_\_\_\_\_



Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Have you suffered an accident? \_\_\_\_\_ Date \_\_\_\_\_

Describe your accident \_\_\_\_\_

MVA / Workers-Comp / Liability:  Yes  No Are you in litigation or is it planned?  Yes  No

Your attorney's name \_\_\_\_\_ Phone \_\_\_\_\_

**Medical History**

Tobacco Use	Prior Surgery		Medical Conditions	
<input type="checkbox"/> Current Smoker Packs Per Day _____	<input type="checkbox"/> Appendix	<input type="checkbox"/> Neck or Back	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer
	<input type="checkbox"/> Gall Bladder	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Never Smoked	<input type="checkbox"/> Cancer	<input type="checkbox"/> Sinus	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Occasional Smoker	<input type="checkbox"/> Tonsils		<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Former Smoker	<input type="checkbox"/> Heart		<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Depression
<input type="checkbox"/> Smokeless Tobacco	<input type="checkbox"/> Other: _____		<input type="checkbox"/> Other: _____	

Caffeine Intake:  Coffee  Tea  Soda How much per day? \_\_\_\_\_ Artificial Sweetener / Diet Drinks:  Yes  No

Alcohol Intake:  Yes  No Type \_\_\_\_\_ How much per day \_\_\_\_\_ How long \_\_\_\_\_

Marital Status  Married  Single  Divorced  Widowed

Do you live alone? \_\_\_\_\_ with a spouse \_\_\_\_\_ with parents \_\_\_\_\_ with children \_\_\_\_\_ with friends \_\_\_\_\_

What is your most physically demanding activity that you do regularly? \_\_\_\_\_  
How often? \_\_\_\_\_

What is your occupation? \_\_\_\_\_

How long? \_\_\_\_\_ Your previous job \_\_\_\_\_

Disabled: When and why? \_\_\_\_\_  
\_\_\_\_\_

**Family History**

Please record any health problems such as high blood pressure, heart disease, diabetes, headaches, seizures, stroke, memory loss, etc.

If deceased, age at death and cause

Father : Living  Yes  No \_\_\_\_\_  
\_\_\_\_\_

Mother Living  Yes  No \_\_\_\_\_  
\_\_\_\_\_

Brothers and Sisters: Living  Yes  No \_\_\_\_\_  
\_\_\_\_\_

Children: Living  Yes  No \_\_\_\_\_  
\_\_\_\_\_





## 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 TO INDIVIDUALS

I, \_\_\_\_\_, give all physicians and professional staff employed by **Medical Associates of Northwest Arkansas, PA**, permission to disclose the private 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 above referenced entity:

Complete Medical Record

or specific information: \_\_\_\_\_

<i>Please Print:</i>	Name	Relationship to Patient
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I also give **Medical Associates of Northwest Arkansas, P.A.**, permission to 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

I understand that **Medical Associates of Northwest Arkansas, P.A.**, will not release any information to any person(s) not listed above.

In addition, I understand or acknowledge the following:

1. I have the right to revoke this Authorization at any time by giving **Medical Associates of Northwest Arkansas, P.A.**, a written notice at the address set forth above.
2. I have received **Medical Associates of Northwest Arkansas** 's Notice of Privacy Practices.
3. My private health care information may be subject to re-disclosure by one or more of the persons named above and as such will no longer be protected.

This Authorization shall expire on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

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

In the event the Authorization is being executed by a personal representative, guardian, or parent, please print your name and relationship to the patient. \_\_\_\_\_

Parent or Guardian Signature \_\_\_\_\_

