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PATIENT REGISTRATION

www.mana.md

Internal Use Only

_____

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

Thank you for choosing a MANA Clinic.

Renaissance
Women's Healthcare Partners
Gynecology and Gynecologic Surgery
A MANA Clinic

New Patient Health Questionnaire
Less than 40 years old

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Name _____ Date _____

Date of Birth _____ Age _____ Primary Care Physician _____ Pharmacy _____

Married __ Single __ Divorced __ Partnered __ *Partner M or F* Employer _____ Job Title _____

ALLERGIES: (include reaction i.e. rash, breathing problems)

_____

MEDICATIONS AND DOSAGES: Include vitamins, minerals and herbals supplements.

_____

_____

HEALTH MAINTENANCE: Have you ever had any of the tests/vaccines listed below? When and what was the result?

	Month/ Year	*Results*	*Treatments*
Pap test			
Any abnormal paps			
Rubella Antibody Test			
Chicken Pox or the vaccine			
Tetanus-diphtheria booster			
Hepatitis B Vaccine			
Cholesterol test			
Gardasil (HPV Vaccine)			

SURGERIES – *Include dates*

_____

MAJOR ACCIDENTS OR INJURIES/HOSPITALIZATIONS – *Include dates*

_____

___ When was the first day of your **last menstrual period**?
___ How many times have you been pregnant?
___ Number of living children
___ Number of Vaginal Deliveries ___ C-sections
___ Number of Abortions
___ Number of Miscarriages
___ How old were you when you started your periods?
___ How often are your periods?
___ How long do you bleed?
Flow of period ___ Light ___ Moderate ___ Heavy
___ Are you having problems with your periods?
If yes, explain_____
___ Are you sexually active?
___ What method of birth control are you using?

___ Are you having any **sexual concerns**?
___ Are you worried about **exposure to STDs**?
___ Have you ever had an STD? Type _____ When _____
___ Are you having problems with **pelvic pain**?
___ Are you having frequent or **painful urination**?
___ Do you have any abnormal **vaginal discharge**?
___ Do you have any abnormal **vaginal itching**?
___ Are you having problems with **urine leakage**?
___ Do you smoke?
☐Current Smoker-Everyday (indicate how much) _____
☐Current Smoker-occasional_____ ☐Former Smoker
☐Never Smoked ☐Smoker-current status unknown ☐Unknown if ever smoked
___ Do you use alcohol or drugs? _____
How often?_____

WHAT ARE YOUR CONCERNS? _____

_____

63 W. Sunbridge, Fayetteville, AR 72703
479.582.3366 (f)479.582.5843 www.mana.md

Name _____ Date of Birth _____

Please check and date the squares below for you and close family members who had any of these diagnoses.

Diagnosis	Self	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alzheimer's									
Alcoholism									
Asthma									
Bladder problems									
Blood Clotting Disorders									
Blood Clots in Legs (DVT)									
Cancer									
Breast									
Cervical									
Colon									
Ovarian									
Uterine									
Other									
Depression									
Developmental delay									
Diabetes									
Endometriosis									
Fibroids									
Gallbladder prob.									
Headache, chronic									
Heart Disease									
Hepatitis/ jaundice									
High Blood Pressure									
High Cholesterol									
HIV / AIDS									
Inherited Disease									
Kidney Disease									
Liver disease									
Lung Disease									
Mental Illness									
Migraines (with or without Aura)									
Obesity									
PCOS									
Seizure Disorder									
Sickle Cell									
Stroke									
Thyroid Disease									
Alzheimer's									

If they pertain to you, please list date and treatment for condition below. Explain above marked diagnoses and any additional problems.

_____

_____

_____

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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/.**
- 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**.**

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/noticepp.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

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:** _____

_____

Please Print: **Name** **Relationship to Patient**

_____

_____

_____

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** _____

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Revised 1/02/14 cbm