

**PATIENT INFORMATION – Please Print**

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

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

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

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

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Preferred communication method:  Text  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 \_\_\_\_\_

Are you of Spanish/Hispanic origin?  Yes  No Preferred (Primary) Language: \_\_\_\_\_

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

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

Would you like to have access to your health records and communicate with your physician office online through a secure myMANA Health Portal?  Yes  No Email \_\_\_\_\_

**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.*

**HOW DID YOU HEAR ABOUT US?**

*Thank you for choosing a MANA clinic. How did you hear about us? Check all that apply.*

- |  |  |
|--|--|
| 01 <input type="checkbox"/> Returning patient                          | 06 <input type="checkbox"/> Location sign or billboard |
| 02 <input type="checkbox"/> Referred by a physician                    | 07 <input type="checkbox"/> Magazine article or ad     |
| 03 <input type="checkbox"/> Referred by a friend or family member      | 08 <input type="checkbox"/> Postcard or letter         |
| 04 <input type="checkbox"/> Google or Internet Search                  | 09 <input type="checkbox"/> Other _____                |
| 05 <input type="checkbox"/> Facebook, Twitter, Pinterest, or Instagram |  |

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

**PERSON RESPONSIBLE FOR PAYMENT**

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 \_\_\_\_\_

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

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

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

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

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

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

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

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

**PATIENT AUTHORIZATION**

I hereby authorize Medical Associates of Northwest Arkansas {MANA}, in its sole discretion, to seek payment of charges for all services rendered during or in connection with my medical treatment from my insurer and/or from third parties {or their insurers} who may have caused, or otherwise be liable for, the incident, injury or condition giving rise to my need for medical treatment. I understand that in the event MANA attempts to collect from those third parties, such attempts are in lieu of, or in addition to, MANA seeking payment from my current medical insurance provider. I understand and agree that any discounts which MANA has agreed to accept from my medical insurance provider will not be applied to reduce amounts payable by, or recoverable from, third parties or their insurers.

I hereby assign and authorize payment directly to MANA of all insurance benefits, sick benefits and injury benefits due because of liability of a third party and proceeds of all claims resulting from the liability of a third party to me or for my benefit unless all charges are paid in full immediately upon completion of my medical treatment. I further agree that this assignment will not be withdrawn at any time until the account is paid in full and consent to MANA's assertion of subrogation or lien rights, if necessary, to protect MANA's interest in recovering from third parties the full amount of charges for services rendered during or in connection with my medical treatment.

I agree to pay at the time of service any co-pay or amount otherwise required by my current medical insurance provider and understand that I am responsible for any amount not covered by Insurance or collected by MANA from a third party. MANA Is authorized to give information regarding me, my case and my medical treatment to my current medical Insurance provider and/or to potentially financially responsible third parties and their insurers.

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



### **Injury Information & Health History**

1. What complaint or symptom prompted your visit to the office today?

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2. When did you first notice the problem?

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3. Do you smoke?  YES  NO  Formerly

4. List ALL medications:

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5. List ALL Drug Allergies (to Medications Only):

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### **Informed Consent**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures including various modes of physical therapy and, if necessary, diagnostic X-rays, on me by Millennium Chiropractic & Rehab, a MANA Clinic, and anyone working in this clinic authorized by Millennium Chiropractic & Rehab, a MANA clinic. I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including but not limited to, muscle strains/ sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgement during the course of the procedure, which the doctor feels at the time based upon the facts then known, is in my best interests. I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

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

### **Consent For Minors:**

I, \_\_\_\_\_ acting as a parent or legal guardian, hereby grant permission and authorize his/her physician to treat \_\_\_\_\_ without the benefit of my presence in the office.

Parent/ Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## Millennium Chiropractic Financial Policy

At Millennium Chiropractic, we want to assist you in coping with your financial requirements. Each health insurance company has different rules for filing claims. You may incur added expense if you fail to follow your insurer's requirements. For patients with insurance, you will be asked to pay any deductibles or co-insurance dictated by your insurance plan at time of service. Our staff will check with your insurance company to get the best estimate of what you will owe for the procedure. Please remember this is just an estimate. The final patient amount owed will be determined after your insurance company processes your claim.

Please understand that ultimately, you are responsible for payment of your account, including any balances not covered by your insurance. At the time of your visit, you are responsible for payment of any known deductibles, co-insurance or co-payments, as well as any non-covered service. We recognize the burden this may place on you or your family and would be glad to discuss a payment plan.

We will only bill insurances provided to us before or at the time of service. Some insurance companies will require prior authorization and we will be unable to retro an authorization after a service is provided. If you do not have your insurance card upon check in and we cannot verify coverage, you will be considered a self-pay patient.

- For your convenience, Millennium Chiropractic accepts most forms of payment including cash, checks, Visa, MasterCard, American Express, Care Credit, and Discover credit cards.
- Payment plans can sometimes be arranged in accordance with Millennium Chiropractic policy.

### No show/Cancellation policy:

Appointments are in high demand and your early cancellation will give another person the possibility to have access to timely medical care. If it is necessary to cancel your scheduled appointment, we prefer you call 24 hours in advance. In order to be respectful of the medical needs of our Community, please be courteous and call promptly if you are unable to attend an appointment.

Late cancellations less than 3 hours in advance will be considered a no show and a \$25 fee will be imposed.

This is not a one-time fee; fees will be assessed each time an appointment has not been cancelled within the adequate time frame.

Three "no-shows" in a 12-month period may result in discharge from Millennium Chiropractic.

We understand there are circumstances that could cause a reason for a "no-show" or a cancellation with short notice. The cancellation policy will be waived for these circumstances on a case-by-case basis.

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

In the event the authorization is being executed by a person representative, guardian, or parent, please print your name, relationship to patient, and basis of the 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:** \_\_\_\_\_



## 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 PRIVATE HEALTH INFORMATION**

**I hereby request that my Private Health Information be released to:**

MILLENNIUM CHIROPRACTIC  
SPORTS MEDICINE AND REHAB  
2744 MILLENNIUM DRIVE, SUITE 1  
FAYETTEVILLE, AR 72703  
PHONE: 479-571-8400      FAX: 479-571-8401

PATIENT NAME: \_\_\_\_\_ D.O.B \_\_\_\_\_

Information to be released to the above referenced entity:

- Complete patient file**
- Or specific information** \_\_\_\_\_  
\_\_\_\_\_

This Authorization shall be deemed to expire the date set forth above my signature or within reasonable time following completion of the event which gave rise to the purpose of this Authorization. I understand that I have the right to revoke this Authorization in writing at any time and that I may do so by delivering a revocation in writing to the Clinic.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the receiving entity and may no longer be protected by the Privacy Standards of this Clinic. The Clinic has informed me that the Clinic will not condition treatment, payment, enrollment, or eligibility for benefits on obtaining this authorization.

I understand that I may refuse to sign this Authorization.

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

## Authorization to Individuals

I, \_\_\_\_\_ give all physicians and professional staff employed by Medical Associates of NWA, PA, 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

Seek Medical Care

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

PLEASE PRINT:	NAME	RELATIONSHIP TO PATIENT	PHONE
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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.
5. My treatment is not conditional on signing this statement, except as allowed by Privacy Rule.

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 \_\_\_\_\_

