mana FAMILY MEDICINE

PATIENT REGISTRATION

www.mana.md

Internal Use Only

_____

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 _____

Ethnicity (Origin): ☐ Not Hispanic or Latino ☐ Hispanic or Latino 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 ☐ Returning patient
02 ☐ Referred by a physician
03 ☐ Referred by a friend or family member
04 ☐ Google or Internet Search
05 ☐ Facebook, Twitter, Pinterest, or Instagram
06 ☐ Location sign or billboard
07 ☐ Magazine article or ad
08 ☐ Postcard or letter
09 ☐ Other _____

COMPLETE REVERSE PAGE ⟹

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#_____

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

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** _____

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FAMILY MEDICINE

ADULT HEALTH HISTORY

Please complete the information below to the best of your knowledge to help the doctor evaluate your health. Ask for assistance at the front desk if you need help filling out this form.

Name _____ Date _____ Date of Birth _____

Why are you visiting the doctor? ☐ General Check-up or Wellness Visit ☐ A particular problem

Do you feel that you are basically healthy? ☐ Yes ☐ No What is bothering you?_____

_____

Family Health History

Name	DOB	State of Health	Age of Death	Health Conditions
Father:				
Mother:				
Siblings:				
Children:				

Mark any diseases known to have occurred in the family with the appropriate initial: **M** (Mother), **F** (Father), **GM** (grandmother), **GF** (grandfather), **A** (aunt), **U** (uncle), **C** (cousin), **B** (brother), **S** (sister).

Alzheimer		Cancer		Hearing Prob.		Obesity	
Asthma		Stroke		Cholesterol		Blood Clots	
Alcoholism		Depression		High Blood Pressure		Kidney Prob.	
Blood Disease		Developmental Problems		Mental Disease		Seizures	
Coronary Artery Dis.		Diabetes		Migraines		Sickle Cell	

About You:

Education: ☐Elementary ☐ High School ☐GED ☐College ☐Graduate School ☐Tech School ☐Trade School

Present Occupation_____ Previous Occupation _____

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced Live with: ☐ Your Family ☐ Alone

Tobacco Use: Type: ☐Cigarettes ☐Smokeless Tobacco

☐Current - Everyday, how much? _____ ☐ Current - occasional, how much? _____

☐ Never ☐Former, how much? _____ ☐User - current status unknown ☐Unknown

Alcohol Use: ☐Yes ☐No ☐Formerly How much and often? _____

Illicit drug use: ☐Yes ☐No ☐Formerly Please list _____---_____

Caffeine: ☐Yes ☐No Type: _____ Amount Daily: _____

Allergic to any medications?_____ If so, what medications? _____

Medications*: Please list medications you take regularly and the dosage.*

Over the Counter (Include vitamins and supplements): _____ _____

Prescription: _____ _____ _____

_____ _____ _____

Your Health History

Office Use

Medical Conditions: ☐ Rheumatic Fever ☐ Kidney Trouble ☐ Prolonged Fever ☐ Heart Trouble

☐ Other _____

_____

Operations	*Type or Cause*	*Where and When*

Injuries	*Type or Cause*	*Where and When*

Have you been in the hospital for anything other than surgeries? ☐ Yes ☐ No

When and Where_____

Please mark "yes" to anything you have experienced recently or frequently: Please answer each question. Any left blank will be considered negative in your medical record.

	Y	N	When		Y	N	When
General:				*Gastrointestinal:*			
Feel anxious, depressed, or irritable				Recent change in bowel habits			
Nervous breakdown				Diarrhea			
Fever, chills, night sweats				Frequent indigestion or gas			
Skin:				*Genitourinary:*			
Skin rashes				Blood in urine			
Eyes, Ears, Nose, Throat:				Burning when you pass urine			
Severe or frequent headaches				Sexually transmitted disease			
Hearing trouble				*Musculoskeletal:*			
Goiter or thyroid trouble				Arthritis			
Vision trouble				Health Changes:			
Respiratory:				Has your weight changed in the past year?			
Shortness of breath				Approximate weight 1 year ago _____			
Asthma				*Other:*			
Cough				Excessive thirst			
Cardiovascular:				Swollen glands			
Heart trouble				Hay fever or allergies			
Pain in chest							

For Women

Are you currently pregnant? ☐ Yes ☐ No Pregnancies(#): ___ Miscarriages:___ Living children ___

Age when menstrual periods began _____ and ended _____.

Are periods regular? ☐Yes ☐No Excess flow? ☐Yes ☐No Spotting between Periods: ☐Yes ☐No

Patient Signature _____ **Date** _____

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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 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**

_____

_____

_____

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** _____

mana medical associates

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