

**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**

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_  
Relative or Friend not in the home

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 |  |

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

## 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? \_\_\_\_\_

Do you feel comfortable filling out medical forms without help?

Never                      Rarely                      Sometimes                      Often                      Always

### Family Health History

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

<i>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).</i>					
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: \_\_\_\_\_





## 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 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 \_\_\_\_\_

