

Today's Date \_\_\_\_\_

Name Change  
 Update  
 New Insurance  
 New Patient

## Patient Information Form

### Patient Information (PLEASE PRINT)

Name \_\_\_\_\_ Sex: M F Status: S M W D

Last First MI

Address \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

City, State, Zip \_\_\_\_\_ SSN: \_\_\_\_\_

Patient Employer \_\_\_\_\_

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

### Spouse Information

Name \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

FATHER'S INFORMATION (IF MINOR)		
Name	SSN	
Address/City/State/Zip		
DOB	Home Phone #	Cell Phone #
Employer		Work Phone #
MOTHER'S INFORMATION (IF MINOR)		
Name	SSN	
Address/City/State/Zip		
DOB	Home Phone #	Cell Phone #
Employer Name		Work Phone #

### INSURANCE INFORMATION (Please allow the receptionist to make a copy)

Medicare# \_\_\_\_\_ Medicaid# \_\_\_\_\_ MediPak# \_\_\_\_\_

**Primary Insurance Co.** \_\_\_\_\_ Eff. Date \_\_\_\_\_

Address/City/State/Zip \_\_\_\_\_ ID# \_\_\_\_\_

Insured Name \_\_\_\_\_ Insured DOB \_\_\_\_\_ Group # \_\_\_\_\_

SSN: \_\_\_\_\_

**Secondary Insurance Co.** \_\_\_\_\_ Eff. Date \_\_\_\_\_

Address/City/State/ Zip \_\_\_\_\_ ID# \_\_\_\_\_

Insured Name \_\_\_\_\_ Insured DOB \_\_\_\_\_ Group # \_\_\_\_\_

SSN: \_\_\_\_\_

**Emergency Contact (Someone other than in your household)** \_\_\_\_\_

Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

**Authorization of assignment of benefits, release of information, and consent for treatment**

I hereby authorize payment directly to Healthcare Plus for services rendered and supplies provided by the physicians, physician assistants, and/or Advanced Practice Nurses of Healthcare Plus. I understand that this assignment is for all benefits otherwise payable to me, but not to exceed my indebtedness to said clinic. I authorize Healthcare Plus to release any information acquired in the course of treatment or examination. I understand that I am financially responsible to Healthcare Plus for charges not covered by this assignment. I authorize the release of any and all medical information necessary to process these claims, and I request payment of benefits due me or for my benefit be made directly to Healthcare Plus.

I hereby authorize and consent to be treated by the physicians, physician assistants, and/or Advanced Practice Nurses of Healthcare Plus. The undersigned consents to any examination, laboratory procedures, anesthesia, or medical services rendered under the general or specific instruction of Healthcare Plus' physicians, physician assistants, or Advanced Practice Nurses. The undersigned recognizes that all persons furnishing **other** professional medical services, including but not limited to, radiology and pathology, are independent contractors and are not employees or agents of Healthcare Plus, and may bill you separately for their services.

The undersigned hereby acknowledges that he or she has read and fully understands the foregoing, and has voluntarily executed this document. The undersigned further acknowledges that he or she is the patient, or is duly authorized by and on behalf of the patient to execute this document, and accepts its forms personally and upon the patient's behalf. The release of information set forth herein above is valid, and the assignment of benefits and financial agreement is valid and binding until final settlement of the account is received.

**Patient's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Personal Representative (if other than the patient)** \_\_\_\_\_

**Relationship** \_\_\_\_\_

**\* Co-Pays are due at the time of service. Payment is expected at the time of treatment unless prior arrangements have been made.**

**\*\* If this is a work-related visit or a motor vehicle accident, please inform the receptionist prior to filling out forms.**

# Healthcare . . . Plus

102 Hamilton Street  
Des Arc, AR 72040

## AUTHORIZATION TO RELEASE AN INDIVIDUAL'S HEALTH INFORMATION TO DESIGNATED PERSON (S)

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**Please read this entire form before completing**

Patient Name: \_\_\_\_\_ SSN \_\_\_\_\_

This form is part of the federal Health Insurance Portability and Accessibility Act of 1996 (HIPAA) requirements for patient privacy. Signing this form and naming a person(s) who can receive your health information allows the staff of Healthcare Plus to release information regarding your healthcare. Examples include, but are not limited to, confirming appointments, giving instructions regarding your care, results of X-Ray or other diagnostic tests, prescriptions, or insurance or financial information.

**Person(s) who can receive information for you:**

(Unmarried students over the age of 18 may wish to list their parents; married persons may wish to list their spouses; widow (ers) may wish to list their adult children or caregiver)

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Phone # \_\_\_\_\_

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***Please initial one of the following choices:***

\_\_\_\_\_ I do not want any mental health information released to anyone other than myself.

\_\_\_\_\_ I authorize the release of my mental health information to the named individual(s).

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Healthcare Plus may leave a message or information by or with:  
(initial all that apply)

\_\_\_\_ Leaving a message on my answering machine, voicemail, or fax

\_\_\_\_ Speaking with whomever answers my telephone

\_\_\_\_ Email at: \_\_\_\_\_

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I hereby authorize Healthcare Plus' staff to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary and that I may revoke this authorization at any time by notifying Healthcare Plus in writing. I understand that once this information is disclosed, the released information may no longer be protected by federal privacy regulations.

\_\_\_\_\_  
Signature of patient or patient's guardian/representative

\_\_\_\_\_  
Date



**Healthcare . . . Plus**

102 Hamilton Street  
Des Arc, AR 72040

**Joint Notice of Privacy Practices (NPP) Acknowledgement**

A Joint Notice of Privacy Practices (NPP) is provided to all patients. This NPP identifies:

1. how medical information about you may be used or disclosed;
2. your rights to access and amend medical information, request an accounting of disclosures, and request additional restrictions on our uses and disclosures of that information;
3. your rights to complain if you believe your privacy rights have been violated; and,
4. our responsibilities for maintaining the privacy of your medical information.

By signing below, I hereby acknowledge receipt of the NPP:

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Name of Patient or Patient's Personal Representative

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Relationship of Personal Representative to Patient (if applicable)

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Signature of Patient or Patient's Personal Representative

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Date

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**For Internal Use Only**

The identity of the requestor has been validated either with a government issued picture ID, such as a driver's license or passport, or comparison of signatures documented in the PHI records.

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Signature of employee validating identity

If applicable, state the reason patient's written acknowledgement could not be obtained:

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