LITTLE ROCK
FAMILY PRACTICE

A Member of Arkansas Family Care Network

PATIENT INFORMATION FORM

FIRST NAME	MIDDLE NAME	LAST NAME
EMAIL ADDRESS	DATE OF BIRTH	SSN

ADDRESS	APT #	MARITAL STATUS

CITY	STATE	ZIPCODE	SEX

CELL PHONE	HOME PHONE	WORK PHONE	EXT

EMPLOYER	OCCUPATION		
WORK ADDRESS	CITY	STATE	ZIPCODE

EMERGENCY CONTACT	RACE	ETHNICITY
RELATIONSHIP TO PATIENT	☐ American Indian / Alaska	☐ Hispanic / Latino
NAME	☐ Native Asian	☐ Not Hispanic / Latino
PHONE NUMBER	☐ Black / African American	☐ Decline to Answer
PREFERRED LANGUAGE	☐ Native Hawaiian / Pacific Islander	
☐ English ☐ Spanish	☐ White	
☐ Other (please specify)	☐ Decline to Answer	

PHARMACY INFORMATION

PREFERRED PHARMACY NAME	PHARMACY ZIP	PHARMACY PHONE

PREFERRED METHOD OF CONTACT

Preferred method of contact for reminder calls and other electronically generated messages?

☐ Voice

☐ Text

REFERRING PHYSICIAN

REFERRING PHYSICIAN	REFERRING PHYSICIAN PHONE

PRIMARY INSURANCE

INSURANCE CARRIER	POLICY NUMBER	GROUP NUMBER
INSURANCE ADDRESS:		EFFECTIVE DATE
POLICY HOLDER	RELATIONSHIP TO PATIENT	
SUBSCRIBER'S ADDRESS		SUBSCRIBER'S SSN
SUBSCRIBER'S DOB	SUBSCRIBER'S SEX (PLEASE CIRCLE ONE)	MALE FEMALE

SECONDARY INSURANCE

INSURANCE CARRIER	POLICY NUMBER	GROUP NUMBER
INSURANCE ADDRESS:		EFFECTIVE DATE
POLICY HOLDER	RELATIONSHIP TO PATIENT	
SUBSCRIBER'S ADDRESS		SUBSCRIBER'S SSN
SUBSCRIBER'S DOB	SUBSCRIBER'S SEX (PLEASE CIRCLE ONE)	MALE FEMALE

I HEREBY CONFIRM THAT ALL THE INFORMATION PROVIDED ME IS ACCURATE.

Printed Patient Name	SIGNATURE (PATIENT OR GUARDIAN IF MINOR)

Consents

If you would like someone else to have access to your protected health information, please list any people authorized to receive your health information with relationship and phone number. By providing this information you give consent to allow the following person(s) access to information on my account that would otherwise be considered Protected Health Information.

Name:	Relationship:	Phone Number:
1.________________	________________	____________
2.________________	________________	____________
3.________________	________________	____________

Assignments of Benefits

I understand and agree that payment of authorized benefits under my insurance carrier(s) will be made to me or on my behalf to the provider for any services or supplies provided by AFCN. I authorize the release of any medical or other information necessary to process an insurance claim on my behalf.

Consent to Treat

I voluntarily consent to care and treatment deemed necessary by the providers at AFCN. My consent includes but is not limited to medical examinations, diagnostic testing, surgical procedures, ultrasounds, laboratory testing, and vaccinations.

Pharmacy Health Information Exchange

I consent that AFCN may obtain my medication history information electronically through a pharmacy health information exchange. AFCN accesses this information to know what medications I am taking so that they can treat me appropriately and avoid adverse drug reactions.

Telemedicine

I consent to participate in any telemedicine/virtual visit that I request or initiate with an AFCN provider.

Communication Consent

I understand and agree that AFCN may contact me using automated calls, emails, and text messaging to my mobile device. These communications may notify me of preventive care, test results, treatment recommendations, outstanding balances, or any other communications from AFCN. If I chose not to receive any or all communications, I must inform the clinic.

By signing, I acknowledge that I have read and understand the policies contained in this document and agree to comply. I further give my consent for the activities described in this document.

____

Printed Name of Patient or Legal Guardian Date

________________________________ ________________

Signature of Patient or Legal Guardian Date

Past Medical History

Patient Name: ______________________ DOB: ______________ Date: _____________

Pharmacy Name & Location: ____

Previous PCP: ___________________________________Reason for Leaving: ______________

How did you hear about us? ____

Past Medical History: Please check if you have had the following:

Cardiovascular
- □ High Blood Pressure
- □ Heart Attack, Year: _______
- □ High Cholesterol
- □ Atrial Fib
- □ Congestive Heart Failure (CHF)
- □ Blood Clots
- □ Peripheral Vascular Disease

Endocrinology
- □ Diabetes
- □ Thyroid Disease
- □ Pituitary Disorder
- □ Adrenal Disorder
- □ Testosterone Deficiency

Pulmonary
- □ COPD/Emphysema
- □ Asthma
- □ Sleep Apnea
- □ Pulmonary Nodule

Neurology
- □ Stroke, Year: _______
- □ Dementia
- □ Epilepsy/Seizure Disorder
- □ Migraine Headaches
- □ Pseudotumor Cerebri
- □ Restless Legs Syndrome
- □ Bell's Palsy
- □ Multiple Sclerosis
- □ Vertigo
- □ Tinnitis

Gastroenterology
- □ Acid Reflux/GERD
- □ Liver Disease/Hepatitis
- □ Celiac Disease
- □ Ulcerative Colitis
- □ IBS
- □ Diverticulosis

Nephrology
- □ Chronic Kidney Disease
- □ Kidney Stones

Hematology/Oncology
- □ Anemia
- □ Sickle Cell Disease/Trait
- □ Bleeding Disorder
- □ Cancer
  Type: ______________

Psychiatry
- □ Depression
- □ Anxiety
- □ Bipolar
- □ Insomnia
- □ ADD/ADHD
- □ PTSD
- □ Schizophrenia

Rheumatology
- □ Rheumatoid Arthritis
- □ Lupus
- □ Fibromyalgia
- □ Osteoporosis
- □ Scleroderma

Infectious Disease
- □ +HIV or AIDS
- □ Tuberculosis
- □ COVID 19
- □ Herpes

Gynecology
- □ PCOS
- □ Endometriosis
- □ Uterine Fibroids
- □ Menopause

Urology
- □ BPH
- □ Erectile Dysfunction

Ophthalmology
- □ Glaucoma
- □ Cataracts

Dermatology
- □ Eczema
- □ Psoriasis
- □ Rosacea
- □ Acne

Orthopedic
- □ Carpal Tunnel Syndrome
- □ Chronic Pain
  Where? ____________

Allergy/Immunology
- □ Environmental/Seasonal Allergies
- □ Immunodeficiency

Other: ____

____

If you are diabetic, when was your last HgbA1C?____________ Result? ____________

When was your last dilated eye exam?________________

What was the result? __________________

Who was the ophthalmologist/optometrist? ______________

When was your last diabetic foot exam?_______________

Exam		Date of Last Exam	Result	Location	Doctor
Pap Smear	(ages 21-65)				
Mammogram	(ages 40-75)				
Bone Density	(over 65)				
Colonoscopy	(over 50)				
PSA	(over 50)				

Continued ....

Past Medical History (continued)

Patient Name: ____________________

Immunizations: Please indicate if you have had the following immunizations and the approximate year

	Yes	No	Year
Pneumovax (age > 65)	Yes	No	______
Prevnar (age > 65)	Yes	No	______
Flu (yearly)	Yes	No	______
Covid (P,M,J&J)	Yes	No	______
Shingrix (age>50)	Yes	No	_____
Tetanus (every 10 yrs)	Yes	No	_____
HPV (age 11-26)	Yes	No	_____

Please list any specialists. (ex. Cardiology, Pulmonary, Neurology, Nephrology, Endocrinology, Gastroenterology, Rheumatology, Pain Management, OBGYN, Ophthalmology, Urology, ENT, Podiatry)

Diagnosis	Specialist Type	Name

Allergies: Please list all drug allergies and/or other allergies

Drug	Reaction

Medications: Please list all current medications (including over-the-counter medications), dosages, how you take them and who prescribes them

Medication	Dosage	Frequency	Prescribing Dr.

Continued ....

Past Medical History (continued) **Patient Name:** ____________________

Surgeries

Date **Surgery** **Reason**

____
____
____
____
____
____
____
____
____

Hospitalizations (other than those associated with surgeries listed above)

Date **Hospital** **Reason**

____
____
____
____
____
____

Tobacco Use

Are you a ☐ current smoker ☐ former smoker ☐ nonsmoker

If you are a current or former smoker, please list how many packs per day: __________

and for how many years: ___________ . Quit date: ______________

Have you had screening for an Abdominal Aortic Aneurysm? Yes _____ No_____

Have you had screening for Lung Cancer by Chest CT? Yes _____ No_____

Sexual History:

Have you had sex in the past 12 months?________________________________

Have you ever had an STD?____

If yes, which one?______________ When? _________________________

Any history of sexual abuse? Yes _____ No_____

Have you used drugs other than those for medical reasons in the past 12 months? Yes _________ No ________

If yes, What drug? ______________________ How often? ________________

Have you had a drink containing alcohol in the past 12 months? Yes_________ No___________

If yes, How often? _________________ How many at each sitting? _____________

How often have you had 6 or more drink on one occasion in the past year? __________

Describe your average daily caffeine intake: ____

Describe any regular exercise: ____

Describe your living situation, including who you live with: __________________________________

____

What is your Martial Status? ____________________ Partner's Name: ______________________

What is your occupation? ____

Any known exposures? ____

Past Medical History (continued)

Patient Name: ____________________

Family History

Members	Status (alive/deceased)	Year of Birth	Diabetes	Hypertension	Heart Disease	Stroke	Kidney Disease	Mental Illness (type)	Cancer (type)	Other
Mother										
Father										
Mom's Dad										
Mom's Mom										
Dad's Dad										
Dad's Mom										
Siblings										
Son(s)										
Daughter(s)										

How many siblings do you have? Brothers ____________ Sisters ______________

How many children do you have? Boys ____________ Girls ______________

Depression Screening

Do you have little interest or pleasure in doing things? Yes __________ No___________

Do you feel down, depressed or hopeless? Yes _________ No__________

If you answered YES, to either of the above questions, complete the following:

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use "x" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed or the opposite being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead, or of hurting yourself in some way				

(Staff Only: If PHQ9>9 add CPT F34.1, Document Intervention)

Fall Risk Assessment

If you are 65 years of age or older, please answer the following:

Have you fallen within the last 6 months? Yes __________ No___________

Do you have a history of falls? Yes __________ No___________

Do you take precautions to prevent falls? Yes __________ No___________

Are you taking any medications that might affect your balance? Yes _______ No________

FAMILY PRACTICE

Patient Name: ____________________ **MRN:** ____________________

DOB: ____________________ **DATE:** ____________________

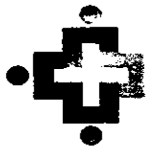
Patient Health Questionnaire (PHQ-9)

Over the last two weeks how often have you been bothered by any of the following problems?

	Not at all (0)	**Several days** (1)	**More than half the days**(2)	**Nearly every day**(3)
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, irritable, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, sleeping toomuch	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching TV	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or hurting yourself in some way	☐	☐	☐	☐

Total Score: _________

For office use only, to be completed by physician



LITTLE ROCK
FAMILY PRACTICE

No-Show Policy

At Little Rock Family Practice, our goal is to provide high-quality, timely care to all our patients. Missed appointments (also known as "no-shows") take valuable time away from other patients who need care. To ensure fairness and efficiency, we have implemented the following No-Show Policy:

Definition of a No-Show:

A **no-show** is defined as missing a scheduled appointment without notifying the office at least a **day in advance.**

No-Show Fees:

- **First No-Show**: $25 fee
- **Second No-Show**: $50 fee
- **Third No-Show**: $100 fee

These fees are not billable to insurance and will be the patient's responsibility.

Consequences of Repeated No-Shows:

If a patient accumulates **three consecutive no-show appointments in a calendar year**, the practice reserves the right to **terminate the patient-provider relationship**. This means the patient may be discharged from the practice and will be given adequate time and assistance to find another healthcare provider.

How to Avoid a No-Show:

If you are unable to keep your appointment, please notify our office **at least one day in advance**. This allows us to offer the time to another patient in need.

Thank you for helping us maintain an efficient and respectful healthcare environment.

Printed Name	Signature	Date

FAMILY PRACTICE

Same-Day Cancellation Policy

At Little Rock Family Practice, we strive to provide timely and efficient care to all our patients. When appointments are canceled on the same day, it limits our ability to accommodate others in need of care. To minimize disruptions, we have established the following Same-Day Cancellation Policy:

Definition of a Same-Day Cancellation:

A **same-day cancellation** occurs when a patient cancels an appointment **on the same day as the scheduled appointment.**

Same-Day Cancellation Fees:

- **First Same-Day Cancellation**: $25 fee
- **Second Same-Day Cancellation**: $50 fee
- **Third Same-Day Cancellation**: $100 fee

These fees are not covered by insurance and are the responsibility of the patient.

Consequences of Repeated Same-Day Cancellations:

If a patient has **three consecutive same-day cancellations in a calendar year**, Little Rock Family Practice reserves the right to **terminate the patient-provider relationship**. The patient will be notified and provided with sufficient time and resources to establish care with another provider.

How to Avoid a Same-Day Cancellation:

To avoid a fee, please notify us of any changes or cancellations **at least 24 hours in advance.** This allows us to better serve all our patients.

We appreciate your cooperation and understanding in helping us maintain a respectful and efficient scheduling process.

____________________ __________________________ ________________

Printed Name Signature Date

Acknowledgement of Notice of Privacy Practices

By signing this form, you acknowledge that you have received our "Notice of Privacy Practices" (the "Notice"). This Notice describes in detail how we might use or disclose your protected health information. The Notice also discusses your rights and our duties with respect to your protected health information. You have the right to review the Notice before signing this acknowledgment.

______________________________	______________
Signature or Patient or Legally Authorize Representative	DATE
______________________________	______________
Printed Name of Patient or Legally Authorized Representative	RELATIONSHIP TO PATIENT

____

If the patient refused or was unable to acknowledge the Notice of Privacy Practices, please explain why:

____

____

____

____

____

____

____

5125 Northshore Drive • North Little Rock, AR 72118 •

Welcome to Arkansas Family Care Network, P.A.

Access your health record.

Anytime, Anywhere.

Stay Connected

* New Portal

healow Portal is a secure, convenient, and easy way to access your health information.

Here's what you can do with our portal

- Send & receive messages securely. Get reminders.
- View labs, medications, and immunization records.

$ Pay your bill

Discover the smarter way to pay online

- Access your statements online from any device
- View your balance and pay online securely
- Keep track of your payment history

healow is free and available on the Apple app store and Google Play store.

DOWNLOAD THE FREE HEALOW APP

1

Download the healow™ app from App Store (iPhone) or Google Play (Android Phone).

2

Search our practice by entering practice code

Practice Code
BEEBDD

3

Enter your portal username and password to login.

4

Set up your PIN to securely access your health records.

Arkansas Family Care network
* North Little Rock

Android App

iPhone App

healow
Health and online Wellness

Financial Policy and Consent Form

Welcome to our clinic! We are committed to providing you with the best care possible. Please read this information carefully.

Financial Information

If you have health insurance coverage, we will file claims on your behalf. Please make sure that you provide current, accurate insurance and policyholder information at each visit. By providing this information to us, you authorize any services furnished to you by our providers to be paid directly to Arkansas Family Care Network, P.A. ("AFCN"). If your health insurance plan requires co-payment, the co-payment is due at the time of service. You are responsible for paying for any services not covered by your insurance, and any deductible or co-insurance is your responsibility. Prior balances are due at the time of service unless prior payment arrangements have been authorized. Please help us by paying your co-payment on each visit.

If you do not have health insurance, you must pay in full at the time of service or make arrangement for payment prior to your scheduled appointment. We accept cash, personal checks, MasterCard, Visa, Discover Card, and American Express.

It is necessary for you to know what benefits your health insurance plan provides for you. Not all services provided are covered by every plan. You should determine whether prescribed testing (lab, radiology, etc.) is covered by your insurance. Additionally, many insurance plans require you to use certain hospitals or doctors and may require pre-certification or referrals to a certain hospital. We are not responsible if you are sent to a hospital that is not covered by your insurance. It is your responsibility to know which doctor or hospital your plan requires you to use.
AFCN will send you a monthly statement for services provided. Payment is due upon receipt of the monthly billing statement. Even if you have insurance, prompt payment of your statement balance is your responsibility.
Accounts not paid in full within 30 days are considered past due. If you cannot make regular payments, please contact us. We may refer your outstanding balance to a collection agency. Any fees incurred in the collection of your outstanding balance will be charged to you.

If your medical care is the result of a work-related injury, your claim will be sent to your employer. They may pay directly or forward to workers compensation carrier for payment. If the carrier information is available to us, we will bill the carrier directly. It is your responsibility to complete any necessary forms to allow us to release information to your employer or the workers' compensation carrier.

If your medical care is the result of a motor vehicle accident or other third-party liability accident, you will need to let us know at the time of service if the insurance claim should be sent to your private health insurance or if the claim needs to be sent to another insurance carrier. We will bill the liability carrier and allow 30 days for payment. You will be responsible for payment on any claims pending litigation or settlement. In the event a work comp, motor vehicle, or third- party liability bill is returned to us as unidentifiable or denied or the claim is pending litigation or settlement, we reserve the right to bill your medical insurance.

Notice of Privacy Practices

Privacy Officer: Hayden Shurgar
EngageMED, Inc.
5410 Northshore Court
North Little Rock, AR 72118
501-320-4815
hshurgar@engagemed.com

Your Information.

Your Rights.

Our Responsibilities.

This notice describes how your medical information may be used and disclosed and how you can access this information. **Please review it carefully.** We reserve the right to change this Notice at any time and apply those changes to all information in our possession. Revised Notices will be available at the clinic and provided to you upon request.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities.

Receive an electronic or paper copy of your medical record	• You can ask to review your medical record or receive an electronic or paper copy of your medical record. 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 will 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 mobile phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

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 not disclose the information 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 have 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 will 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 1. • 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 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 • Most sharing of substance abuse treatment records • All other uses not covered by this notice
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.

Your treatment	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.*

continued on next page

How else can we use or share your health information? We are allowed and required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions 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 are 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.

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 provide you with 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. You may revoke your authorization at any time by telling us in writing. Revocation will not apply to an action based on a prior authorization.