LINCOLN PADEN
MEDICAL GROUP

New Patient Paperwork

To provide you with the best care, we need to know the following information. Please take a few minutes to answer all questions. Please print your information. If you need any help with this form, feel free to ask us! Thank you.

Patient's Name: _____

Patient's Preferred Name: _____

If Minor, Parent or Responsible Party: _____ Relationship: _____

Mailing Address: _____

Phone: _____ How may we contact you? ☐ Phone ☐ Text ☐ Email

Email: _____ Pharmacy: _____

Birthday: _____ Sex: _____ SSN: _____

Marital Status: ☐ Single ☐ Divorced ☐ Widow
☐ Married ☐ Separated ☐ Partner

Language: ☐ English ☐ Spanish Other _____

Race: ☐ White ☐ Asian ☐ Native American
☐ Black ☐ Hispanic ☐ Other _____ ☐ Decline to Answer

Emergency Contact

Name: _____ Relation: _____

Phone: _____ HIPPA: YES NO

Insurance: _____

Member Name: _____

Member No: _____ Group No.: _____

Insurance: _____

Member Name: _____

Member No: _____ Group No.: _____

Employer: _____ Occupation: _____

Address: _____ Phone: _____

Spouse's Name _____ Spouse's Employer _____

Have you traveled out of the State or Country in the last 30 days? Yes No Where? _____

Have you had contact with anyone that has been out of the State or Country in the last 30 days? Yes No

Patient/Parent/Guardian Signature: _____ Date: _____

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`Patients Name:

DOB:

PHI Communication Resource Tool

Please print below

I, _____, herby authorize release of my Protected Health Information for discussion of my care or treatment to the person(s) specified below (45CFA, 164.502(F) & 164.502 (G):

Authorized family member or person to receive verbal information for the above-named patient's care:

Name of Central Contact	Relation to Patient	Phone
Secondary Contact	Relation to Patient	Phone
Secondary Contact	Relation to Patient	Phone

Note: This form does not give the above referenced persons permission to make health care decisions for the patient or entitle them to paper or electronic copies of the patient's medical record. We will not release via telephone or any other means of communication any information to any friends or family members not listed above unless the patient has an opportunity to object and does not (Documented) or if it is reasonable to infer that the patient does not object such as when a patient brings a spouse into the room when treatment is being discussed. Exception: If the release is needed in emergency situations.

Do you wish to be confidential or non-published patient for directory status? ☐ YES ☐ NO

Example: We will not acknowledge that you are a patient if someone calls or comes into the clinic.

May we leave a message for the patient on an answering machine or voicemail? ☐ YES ☐ NO

Example: We may leave reminders, scheduling changes or notices that lab results are in on your answering system.

May we leave a message for the patient to return our phone call? ☐ YES ☐ NO

Example: We may leave reminders, scheduling changes or notices that lab results are in with whomever answers the phone.

Acknowledgement Statement: *Check One*

I have been offered a copy of the Notice of Privacy Practices and **received** a copy. ____

I have been offered a copy of the Notice of Privacy Practices and **declined** a copy. ____

Patient or Legal Personal Representative: _____ Date: _____
signature

Patient or Legal Personal Representative: _____ Relationship _____
printed

Note: Except to the extent that action has already been taken in reliance on this PHI Communication Resource Tool, at any time I can revoke this PHI Communication Resource Tool by submitting a notice in writing to the Privacy Site Coordinator or Privacy Site Designee.

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Which doctor are you seeing today?
Circle One

- ☐ Dr. Cara Ballard
- ☐ Dr. Shelley Warr
- ☐ Dr. Lance Lincoln
- ☐ Dr. John Baltz
- ☐ Dr. James Warr

Why are you seeing the doctor today? _____

When did you first start having this problem? _____

Do you take any prescribed medicine, over the counter, non-prescribed, or health supplements?

List All Medications or Supplements

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Allergies

Are you allergic to any medications, prescribed or over the counter? ☐ YES ☐ NO

If yes, please list medications and the reaction you had. Include aspirin, Tylenol, vitamins, over the counter medications, herbal remedies, etc.

_____

_____

Are you allergic to any food? ☐ YES ☐ NO

If yes, please list food and reaction you had.

_____

_____

Past Medical History

Do you see a doctor regularly for any medical reasons ☐ YES ☐ NO
Have you had any diseases or health problems in the past? ☐ YES ☐ NO

Surgical History

Have you had any surgery in the past? ☐ YES ☐ NO
If yes, please list the date and type of surgery.

_____

_____

_____

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New Patient Paperwork

Family History

Are there diseases or illnesses that family members have had? Please check the boxes below for any family member who has had the problem.

Family Members	State of Health	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Unknown
Father								
Mother								
Paternal Grandfather								
Paternal Grandmother								
Maternal Grandfather								
Maternal Grandmother								
Siblings								
Children								

Social History

Do you smoke, have you ever? ☐ Yes ☐ No

If yes, much per day? _____ Type_____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how much and how often? _____

Do you take any drugs for reasons that are not medical? ☐ Yes ☐ No

If yes, please list: _____

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General
- ☐ Change in appetite
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss

Gastrointestinal
- ☐ Abdominal pain
- ☐ Blood in stool
- ☐ Constipation
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Vomiting

Musculoskeletal
- ☐ Neck pain
- ☐ Back pain
- ☐ Joint stiffness
- ☐ Leg cramps
- ☐ Muscle aches
- ☐ Painful joints
- ☐ Swollen joints
- ☐ Weakness

Breast
- ☐ Breast lump
- ☐ Breast pain
- ☐ Nipple Discharge

Ear/Nose/Throat
- ☐ Blacked ear
- ☐ Nosebleeds
- ☐ Sore throat

Eyes
- ☐ Blurred vision
- ☐ Cataracts
- ☐ Glasses
- ☐ Contacts
- ☐ Glaucoma
- ☐ Itching / redness

Respiratory
- ☐ Cough
- ☐ Coughing up blood
- ☐ Coughing up mucus
- ☐ Wheezing

Genitourinary
- ☐ Blood in urine
- ☐ Difficulty urinating
- ☐ Frequent urination
- ☐ Painful urination

Skin
- ☐ Itching
- ☐ Noles
- ☐ Rash

Neurologic
- ☐ Stroke
- ☐ Dizziness
- ☐ Fainting
- ☐ Memory Loss
- ☐ Seizures

Cardiovascular
- ☐ Chest pain at rest
- ☐ Chest pain with exertion
- ☐ Irregular heartbeat

Women Only
- ☐ Irregular menses
- ☐ Missed periods
- ☐ Painful menses

Hematology
- ☐ Easy Bruising
- ☐ Swollen glands

Conditions: Check conditions you have now or have ever had.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bulimia
- ☐ Anorexia
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ HIV Positive
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Prostate trouble
- ☐ Psychiatric care
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Ulcers
- ☐ Venereal disease

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ **Date of Birth:** _____

Phone: H) _____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address: _____ **Facility Fax:** _____

City, ST, Zip: _____

Dates and Type of information to disclose:

☐ 2 years prior from last date seen
☐ Dates Other: _____
☐ Specific Information Requested:

_____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral
☐ Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: Lincoln Paden Medical Group

Address: 405 Buttercup Dr

City, State, Zip: Mountain Home, Ar 72653 ☐ **Please mail records.**

Fax: 870-425-0633 **Phone:** 870-425-3030 ☐ **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____ _____

Signature of Patient / Parent / Guardian or Authorized Representative (Guardian or Authorized Representative must attach documentation of such status.) **Date**

_____ _____

Printed name of Authorized Representative Relationship / Capacity to patient

_____

Address and telephone number of authorized representative

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HIPAA Notice of Privacy Practices

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.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose to providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. *For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.*

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. *For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.*

Healthcare Operations:
We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. *For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health related benefits and services that may be of interest to you.*

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO)and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services.

We may use or disclose your protected health information in the following situations without your authorization. These situations include as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, and notional security, worker's compensation, inmates, and other required uses and disclosures. Under the Law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and required Uses and Discloseures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorizations.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to Inspect and copy your protected health information (fees may apply) Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request to receive confidential communications – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications. You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure. You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice, and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide Individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying – Acknowledgment- form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.