Carriage Hill Family Care, PLC
3501 Carriage Hill Dr Ste B | Paragould, AR 72450
Phone: (870) 573-2200 | Fax: (870) 573-2300

Welcome to Carriage Hill Family Care, PLC

What to Expect During Your First Visit

Thank you for choosing Carriage Hill Family Care, PLC for your health care needs. During your first visit, you will meet our staff, complete a few brief forms and, of course, meet your medical provider. As family health providers, we serve patients of all ages from newborns to great grandparents. We will try to solve your current medical problem and detect or prevent other health problems. We hope to make the first visit not just an opportunity to deal with any medical concerns you may have but also a time to get acquainted with you.

The First Examination

When you enter the exam room, you will be asked to fill out a health questionnaire by a staff member. We will measure your height and weight, take your temperature, and check your blood pressure. We will review the health questionnaire, review your medications, allergies and ask you additional questions pertinent to your issues. We will also record the data into our secure electronic medical records. Thank you for your patience. Depending on your problem, you may be asked to undress and put on a gown in the privacy of the exam room. This enables us to better evaluate your health. After the examination, your medical provider will suggest a treatment plan and future visits, if necessary.

We hope that after your visit you will feel confident that you have made a wise decision by choosing our practice. If you have any feedback, please ask our front staff to provide you with a feedback card or go to our website at www.CHFamilyCare.com to send us an email.

Thank you for allowing us to participate in your health care,

Carriage Hill Family Care, PLC

Our Providers

Dr. Vincent Lee, MD
Cecil Massey, APRN
Teresa Gonzalez, APRN
Latoya Coward, APRN
Lauren Willmer, APRN
Allyssa Beall, APRN
Diane Underwood, APRN
Laura Needham-Puckett, EdS, LPC-S, RPT-S

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Patient Registration (Please Complete ALL Forms)

Date: _____ **Account Number: _____**

Name: (Last)_____ (First) _____(Middle)_____

Mailing Address: _____

Physical Address: _____

City: _____ State: ____ ZIP: _____

Birth Date: _____ Soc. Sec. No: _____ Sex: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Emergency Contact: (Name) _____ (Phone) _____ (Relationship) _____

Local Pharmacy: _____ Town: _____

Preferred Language: _____ Level of Education: _____

Marital Status: Married Single Widowed

Do you smoke? No Yes If so, how many packs per day?_____How many years?_____

Race: White Black Asian Pacific Islander Multi-Racial Hispanic Other:_____

Responsible Party if under 18 yrs of age: Self Spouse Parent Guardian

Name: (Last) _____ (First) _____ (Middle) _____

Address: _____

City: _____ State: ____ ZIP: _____

Birth Date: _____ Soc. Sec. No: _____ Sex: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email:_____

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Insurance Information

Primary Insurance: _____

Name of Insured: (Last) _____ **(First)** _____ **(Middle)** _____

Insured Party: Self Spouse Parent Other **Insured's Date of Birth:** _____

ID #: _____ **Group #:** _____

Insurance Address: _____

City: _____ **State:** _____ **ZIP:** _____

Secondary Insurance: _____

Name of Insured: (Last) _____ **(First)** _____ **(Middle)** _____

Insured Party: Self Spouse Parent Other **Insured's Date of Birth:** _____

ID #: _____ **Group #:** _____

Insurance Address: _____

City: _____ **State:** _____ **ZIP:** _____

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If you have any other insurance policies, please ask the receptionist for an additional form.

Please present your insurance cards to the receptionist.

I authorize the release of all information of any kind that you may have regarding me, including but not limited to, all medical and other records, reports, bill, and other information of any kind. This authorization also specifically authorizes the release of any such information regarding drugs, alcohol, or H.I.V. I authorize the release of medical information necessary to process claims filed on my behalf.

A photocopy of this medical authorization shall be as effective as the original. This authorization is valid for 18 months from the date hereof.

X_____ **X**_____

Patient's/Guardian's Signature **Insured's Signature**

_____

Date

I authorize payment of medical benefits to be made directly to the supplier or provider of services performed. This authorization is valid for 18 months from the date hereof.

X_____ **X**_____

Patient's /Guardian's Signature **Insured's Signature**

_____

Date

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HIPAA Authorization Form for Family Members/Friends

I, _____(Print), give permission to all my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name(s): *Relationship:*

_____ _____

_____ _____

_____ _____

Health Information to be disclosed (Check all that apply):

- ☐ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR
- ☐ My complete health record, as above, with the exception of the following information:

(check as appropriate):

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify_____
  _____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:_____
  unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

X _____
Name of the Individual Giving this Authorization

X _____ _____
Signature of the Individual Giving this Authorization Date

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PATIENT HISTORY (Please Complete ALL Forms)

NAME: **DATE:**

DRUG ALLERGIES (Include Type of Reaction)

CURRENT MEDICATIONS (Include Name, Dose, Frequency)

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Bleeding Disorder						
Diabetes						
Epilepsy/Convulsions						
Glaucoma						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Lung Disease						
Mental Illness						
Stomach/Colon						
Stroke						
Thyroid Disease						
Cancer Type (important):						
Other:						

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PATIENT HISTORY (Please Complete ALL Forms)

NAME:

PAST MEDICAL HISTORY (Circle all that apply)

Recent Weight Loss	Heart Attack	Irritable Bowel Syndrome
Migraine Headaches	High Blood Pressure	Constipation
Epilepsy/Convulsions	High Cholesterol	Other Bowel Problems
Eye Disease (Other than glasses)	Congestive Heart Failure	Liver/Hepatitis
Neurological	Stroke	Kidney/Bladder
Hearing Disorder	Heart Valve Disorder	Anemia
Depression	Angina – Chest Pain	Arthritis
Anxiety	Asthma	Autoimmune Disease
ADHD	COPD	Osteoporosis
Other Mental Illness	Other Lung Disease	Blood Transfusion
Recurrent Nose Bleeds	Diabetes	Stomach Ulcer
Recurrent Sinus/Throat Infections	Alcoholism	Bleeding Disorder
		HIV
OTHERS:	CANCER – Type:	

PAST HOSPITALIZATION OR SURGERIES

REASON:	DATE:

IMMUNIZATIONS

NAME	DATE
Influenza vaccine	
Hepatitis B	
Pneumonia	
Tetanus	

HABITS

Alcohol—Type/Amount:
Any illegal drugs?:

CANCER SCREENING

Colorectal Cancer (e. g. Colonoscopy)
Date:
Normal: Yes No

FOR WOMEN ONLY

Date of last period:
Do you use birth control: Yes No
Type of birth control:
of pregnancies: # of live births:
of miscarriages: # of abortions:
Date of last PAP: Normal: Yes No
Mammogram: Normal: Yes No

CONSENT: I voluntarily consent to receive medical and healthcare services from Carriage Hill Family Care, PLC (referred to hereafter as "provider". I understand this may include services by my provider, provider's assistants and designees, including medical students, residents or fellows, and employees of provider as is deemed necessary or advisable in their judgment. I authorize the use of telehealth services, photographs, camera surveillance and/or video recordings as needed for the purpose of treatment, payment, or healthcare operations. I authorize the disposal of any tissues removed in the performance of any procedure. I am aware that the practice of medicine and surgery is not an exact science; that it involves my informed acceptance of certain risks versus benefits, and I acknowledge that no guarantees have been made to me as a result of my examination and/or treatments.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all rights and benefits to which I may be entitled arising out of any healthcare or liability insurance policy, Medicare or Medicaid to provider. I authorize the full and undiscounted pursuit of payment on my account from any available liability insurance policy or third party source before submission of my account for payment to my own health insurance company or to Medicare or Medicaid. I hold provider harmless of any reduction in healthcare benefits by my insurance company resulting from noncompliance with any clause or condition contained in my policy which may require: Notification; Precertification; Prior to Retrospective Authorization; or Utilization Review of the medical services I receive. Assignment of Insurance benefits is valid and binding until final payment of the account is received.

FINANCIAL RESPONSIBILITY AND PAYMENT REQUEST: The undersigned, jointly and severally, in consideration for the services rendered to the above-named patient, accepts financial responsibility and agrees to pay in advance any applicable deductibles, copayments, coinsurance and estimated self-pay dollars and to pay in arrears the facility's rates and terms for services rendered to the patient upon receipt of a statement for such charges. The undersigned further agrees that if such indebtedness is placed in the hands of a collector or an attorney for collection, the undersigned will pay reasonable attorney fees, interest, court costs and other collection costs and expenses. I also understand that I may qualify for financial assistance programs and that I may secure a determination of such upon request. I further understand that such a determination is dependent upon my timely submittal of appropriate financial documentation and my failure to provide any such documentation could affect my qualification for financial assistance. I request that payment of authorized benefits be made on my behalf. I assign payment for unpaid charges for certain physicians' services furnished by specialists, and physicians for whom provider is authorized to bill. I understand that I am responsible for any health insurance deductibles and coinsurance. I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I agree that I am financially responsible for deductibles and co-insurance not covered by my insurance.

CONTACT BY PHONE:

COMMUNICATIONS REGARDING MY ACCOUNT:
I agree that provider, any other collection or servicing agency, or agencies retained by provider (together referred to hereafter as "collectors") to collect any money that I owe to provider may contact me by telephone or text message at any number associated with my personal demographic information. I understand that this contact includes but is not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge, and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages.

COMMUNICATIONS REGARDING MY CARE:
I agree that provider may contact me by telephone or text message at any number associated with my personal demographic information for the purpose of care coordination, quality improvement activities, appointment reminders and wellness campaign reminders. I understand that this contact includes but is not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text

message. I understand, acknowledge and agree that provider may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages.

RELEASE OF INFORMATION AGREEMENT: I understand provider will generate, receive and store protected health information regarding my diagnosis and /or treatment. This information could include mental illness information, use of drugs and alcohol, or communicable diseases such as HIV/AIDS. I understand that the Notice of Privacy Practices provides information about how provider and its workforce may use and/or disclose my information for the purposes of treatment, payment, healthcare operations and otherwise required by law. I hereby authorize provider, in its discretion, to disclose any or all of the information in my medical records to any person, corporation or agency which is or may be liable for all or part of provider's charge or who may be responsible for determining the necessity, appropriateness, amount, or other matter related to treatment or charges, including, but not limited to, insurance companies, health maintenance organizations, preferred provider organizations, workers compensation carriers, welfare funds, and the Social Security Administration or its intermediaries or carriers. I further authorize provider, in its discretion, to disclose such information to its insurance carrier or carriers when so requested by such carrier and to my employer when said employer is liable for such charges.

This document shall be signed by the patient, his or her legal guardian, or by another competent individual due to the reason outlined below. The undersigned certifies that he/she/them has read or has been read this form, has received a copy, is the patient or authorized representative of the patient, and the conditions of admission are fully understood and accepted.

X_____

Signature of Patient

If patient is unable to consent or is a minor, complete the following:

Patient is _____ years of age or is unable to consent because

_____

I am legally authorized to execute the above by virtue of my relationship to the patient as (circle one)

Father Mother Legal Guardian Other_____

X_____ **X**_____

Signature of Person Giving Consent Print Name of Person Giving Consent

Two (2) Witnesses Required for Verbal or Telephone Consent:

X_____ **X**_____

Employee Name & Signature Employee Name & Signature

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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.

To Our Patient: The providers and staff of Carriage Hill Family Care, PLC are committed to the protection of your health information. The Health Insurance Portability and Accountability Act, requires that we provide notice to each of our patients of how this information is used. We safeguard information about your health and your person (Protected Health Information, PHI). We collect information from you and keep it in a designated record set that contains your health and billing information.

1. USES AND DISCLOSURES AND PROTECTED HEALTH INFORMATION

Treatment: We will use and disclose your health information to provide, coordinate, and/or manage your healthcare and any related service. For example,

- Sending you an appointment reminder
- Obtaining your medical treatment and history and recording it in your chart
- Discussing your care with another healthcare provider

Payment: Your protected health information will be used, and disclosed as necessary, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for your services such as determining eligibility and coverage and utilization review.

Healthcare Operations: We may use or disclose, as necessary, your protected health information to support standard business activities. These activities include, but are not limited to, quality assessment and improvement activities, training of medical students and licensing.

We will share your protected health information with third party business associates that perform various activities for Carriage Hill Family Care, PLC. Whenever an arrangement such as this involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect your privacy. For example,

- A contract exists between us and the companies that do our medical transcription.
- A contract exists between us and the collection agency that handles our past due accounts.

2. OTHER USES AND DISCLOSURES BASED UPON YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke your authorization at any time in writing. There may be cases where your protected health information has already been released prior to the revocation of the authorization.

3. DISCLOSURES TO WHICH YOU HAVE THE OPPORTUNITY TO OBJECT

Others Involved in your Healthcare: Unless you object, we may discuss your protected health information with family members or close friends. The information disclosed will only be that related directly to this person's involvement in your care. If you are unable to agree or disagree, we may disclose this information if we determine that it is in your best interest based on our professional judgment. For example,

- We may discuss your continuing care plan with the individuals participating in your care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation.

Communication Barriers: We may use and disclose your protected health information if we are unable to obtain consent from you but feel in our professional judgment that you intend to consent.

4. USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include, but are not limited to:

Required by Law: We will disclose your protected health information when required to do so by federal, state, or local law.

_ Public Health Reporting: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive information.

_ Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

_ Health Oversight: We may disclose your information to health oversight agencies for activities authorized by law such as audits, investigations, and inspections.

_ Abuse and/or Neglect: We may disclose your protected health information to a governmental entity or agency authorized by law to receive reports of suspected abuse/neglect.

_ Food and Drug Administration: We may disclose your protected health information to a person or company required by the FDA to report adverse events, product defects, biologic product deviations, etc.

_ Legal Proceedings: If you are involved in a lawsuit, we may disclose your protected health information in response to a court order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process from someone else involved in the lawsuit, but only if efforts have been made to tell you about the request or to obtain an order from the court.

_ Law Enforcement: We may disclose protected health information, so long as applicable requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death or injury has occurred as a result of criminal conduct, (5) in the event that a crime occurs on property owned or operated by Carriage Hill Family Care, PLC, and (6) in the event of a medical emergency.

_ Coroners, Funeral Directors, and Organ Donation: We may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death, or for them to perform other duties as required by law. Your protected health information may also be disclosed to a funeral director, as authorized by law, in order for the director to carry out their duties. We may disclose such information in the reasonable anticipation of death. Protected health information may be used and disclosed for cadaver organ, eye, or tissue donation purposes.

_ Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

_ Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel, (1) for activities deemed necessary by appropriate military command authorities, (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities.

_ Worker's Compensation: Your protected health information may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally-established programs.

_ Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

_ Other Required Uses and Disclosures: Under the law, we must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et.seq.

5. YOUR RIGHTS

You have the right to inspect and obtain a copy of your protected health information. This means that you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain your protected health information. A designated record set contains medical and billing records and any other records that we use in making decisions about you. You may request the record be provided in paper or electronic format. You may be charged a fee for the cost of copying, mailing, or supplies associated with your request.

Under federal and state law, however, you may be denied access to inspect or obtain a copy. Please contact the clinic manager if you have any questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means that you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. 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.

Your request must state the specific restriction requested and to whom this restriction applies. You may also request restriction of PHI to a health plan with respect to health care for which you have paid for in full out of pocket. The request and payment must occur in writing in advance of the services being provided.

The provider is not required to agree to the restriction that you request, except in the case of a requested restriction of PHI to a health plan for purposes of payment or healthcare operations with respect to health care for which you have paid for in full out of pocket. If the provider believes that it is in your best interest to permit use and disclosure of your protected health information, it will not be restricted. Please discuss any restriction you wish to request with your provider.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of any alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to the privacy contact listed below.

You have the right to request an amendment to your protected health information. This means that you may request an amendment of protected health information about you in a designated record set for as long as we maintain the information. In certain cases, we may deny your request for an amendment. If we deny your request, 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. Please contact the clinic manager if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures made for purposes outside those for treatment, payment, and healthcare operations. You have the right to receive specific information regarding non routine disclosures that occurred after April 14, 2003. We must respond within sixty (60) days. You may request a shorter timeframe. You are entitled to receive one (1) free accounting each year. There will be a fee for any additional accounting requests during the year. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

You have the right to obtain a copy of this notice from us. Upon request, you may receive an additional paper or electronic copy of this notice from us.

You have the right to receive a notice following a breach of your unsecured PHI.

6. COMPLAINTS

If you believe your privacy rights have been violated by Carriage Hill Family Care, PLC, you may file a complaint with us by contacting the clinic manager who serves as our Health Privacy Officer at (870) 573-2200. You may also file a complaint with the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint. We will not require you to waive the right to file a complaint with HHS as a condition to receive treatment from us.

7. ADDITIONAL INFORMATION

This notice was updated, published and becomes effective on February 3, 2022. Carriage Hill Family Care, PLC has a duty as your healthcare provider to maintain your privacy, abide by the terms of this privacy notice, and provide you with a revised copy of this notice if revisions are made.

We reserve the right to change this notice. We reserve the right to make the revised notice effective for protected health information we already have as well as any information we create or receive in the future.

Received by

X_____ _____

Signature Date

Carriage Hill Family Care, PLC
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AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____ Date of Birth:_____

Phone Number_____ Last Four Digits of Social Security Number:_____

Address_____

Email Adress_____

PARTY TO RECEIVE INFORMATION:

I hereby authorize: _____
Entity, person(s), or class of persons

To release to: Carriage Hill Family Care, PLC and its physicians' employees and agents

TYPES OF INFORMATION:

Date(s) of Service Requested: _____
_____ Entire Medical Record Including any Psychotherapy Notes
_____ Other Speciific Information: _____

I understand the record may include information relating to mental healthcare, communicable diseases, and treatment of alcohol or drug abuse.

I request the record to be provided in the following format:
_____ paper _____ CD _____ unsecure email

I understand if I request the record to be provided by email that I undertake the following potential risks:

- The information may be obtained by someone else
- The information can be opened and read by someone else
- Unencrypted information does not provide any assurance of privacy or security

X_____ _____
Patient Signature Date

X_____ _____
Legal Representative, if not patient Date