PrimeCARE MEDICAL CLINIC

DEMO/HIPAA

Patient Information Record

Today's Date: _____

Patient Name: _____ Date of Birth: _____
First Middle Last

Mailing Address: _____
Street Apt # City State / Zip

Home Phone #: _____ Cell Phone #: _____ Sex: ☐ M ☐ F

SSN: _____ Race: ☐ Asian ☐ Black /African-American ☐ Caucasian ☐ Hispanic ☐ Other

Email Address: _____ Marital Status: ☐ M ☐ S ☐ D ☐ W

Patient's Employer: _____ Patient Work Phone #: _____

Choose One

☐ I use PrimeCare for all my urgent and primary care health

☐ I use PrimeCare for all my urgent health needs and see _____ for my Primary Care needs.

Emergency Contact: _____ Address: _____

Relationship to Patient: _____ Cell Phone #: _____

IF PATIENT IS MINOR OR DEPENDENT

Contact #1: (*CIRCLE ONE*) Father / Mother / Legal Guardian Name: _____
First Last

Date of Birth: _____ Address: _____
Street Apt # City State / Zip

Cell Phone #: _____ Social Security Number: _____

Contact #2: (*CIRCLE ONE*) Father / Mother / Legal Guardian Name: _____
First Last

Date of Birth: _____ Address: _____
Street Apt # City State / Zip

Cell Phone #: _____ Social Security Number: _____

INSURANCE INFORMATION (Please fill out even though we scanned in your card)

*Primary Insurance Company: _____ Employer: _____

PT ID #: _____ Group #: _____ Policy Holder: _____

Patients Relationship: _____ Policy Holders DOB: _____ SSN: _____

Claims Mailing Address: _____
Street Apt # City State / Zip

*Secondary Insurance Company: _____ Employer: _____

PT ID #: _____ Group #: _____ Policy Holder: _____

Patients Relationship: _____ Policy Holders DOB: _____ SSN: _____

Claims Mailing Address: _____
Street Apt # City State / Zip

Patient Authorization:
I authorize PrimeCare Medical Clinic to apply for benefits on my behalf for services rendered. I certify that the information I have reported to PrimeCare with regard to my insurance is correct. I also authorize the release of any necessary information, including medical information if requested by my insurance company. I permit a copy of this authorization to be used in such instances. By signing below, I agree to pay all charges for services rendered by PrimeCare which are not covered by my insurance. If it becomes necessary for PrimeCare to seek judicial action to enforce the above agreement, I agree to pay all collection fees and all attorney's fees of PrimeCare for such action.

Referrals:
I am responsible for obtaining a valid referral form from my Primary Care Physician if required by my insurance.

Pre-Certifications:
I understand that PrimeCare will attempt to obtain a pre-certification as a courtesy for me. I understand that PrimeCare is not obligated to obtain pre-certification for me and it is my responsibility to obtain or to make sure that any required pre-certification has been obtained for me prior to my procedure. I agree to advise and confirm with PrimeCare that a pre-certification has been obtained for me. I understand in the event pre-certification is not obtained by me, I will be responsible for any amounts not paid, reduced, or denied by my insurance company.

Policy Regarding Payment of Medical Bills:
I agree to pay promptly all charges billed for medical services rendered. As a parent or guardian, I accept legal responsibility for all charges incurred by the patient named on the previous page.

Policy Regarding Medical Records:
I hereby authorize PrimeCare Medical Clinic to release my medical information as I have directed. I understand that PrimeCare Medical Clinic does not copy records and that such record copying services are subject to a copying charge. I also understand that said records must be requested at least one week in advance of desired receipt date. I understand that the cost for copying/printing medical records is $ 0.50/page for the first 25 pages and $0.25 for each additional page. Additionally, a labor charge of $15.00 may be added for each medical record request. I understand I will be billed by PrimeCare Medical for copying those records. Patients or other parties authorized by the patient to request records for legal issues, insurance, disability (not workman's comp), physician change, or relocation are subject to a copying charge. There will be no charge for copying records for a referral to another physician made by a PrimeCare Medical Clinic provider, or workman's compensation issues or any other situations covered by Arkansas Law.

Telemedicine:
At the recommendation of the PrimeCare medical provider and with my permission, I hereby authorize my consent to receive Telemedicine services at PrimeCare Medical Clinic. I understand that my image and my protected health information will be transmitted electronically through the videoconference platform to authorized PrimeCare medical personnel for the purpose of providing medical diagnostic assessment and treatment services. I understand that I can withdraw this permission at any time prior to the videoconference, of which shall carry no negative impact on my ability to continue care at PrimeCare. I understand that there are limits to Telemedicine technology and there is no guarantee that a Telemedicine session will eliminate the need for me to see a provider in person in order to receive appropriate or additional treatment for my current condition.

Patient Right to Privacy/Confidentiality:
PrimeCare is committed to patient privacy and confidentiality in compliance with HIPAA. Please complete the following so we can ensure the privacy and confidentiality of your information to the degree required under existing regulations. I authorize PrimeCare Medical Clinic to leave medical information pertaining to my care by the following methods and know that it is my responsibility to update this information should the information change:

Please provide the best contact number to reach you:

_____

Okay to leave message? ☐ Yes ☐ No

Okay to text phone? ☐ Yes ☐ No

List any people authorized to receive your health information with relationship and phone number:

Name	Relationship	Phone #:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

I have read and understand the above information:

_____ _____

Signature of Patient Parent/Guardian Date

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. This Notice describes the types of uses and disclosures of my protected health information (PHI) that might occur in my treatment, payment of my bills, or in the performance of health care operations. This form will be filed in the patient's medical record.

Please Print the Patient's name

Date

Please Sign your name

Legal Representative or parent's name if patient is a minor

Relationship to Patient