ARcare

WELCOME TO ARCARE ➤ ARcare.net

All clinics are open Monday-Friday 8 a.m. to 5 p.m. with some evening and weekend hours. If you need medical services after regular business hours, please call:

ARcare 501.268.6121 | KentuckyCare 877.791.9154 | MississippiCare 501.530.6016

PATIENT DEMOGRAPHIC

Patient Name

Date of Birth

Social Security No.

Mother's Maiden Name

Sex

Gender Identity

Sexual Orientation

Marital Status

Race

Ethnicity
☐ Latino/Hispanic
☐ Not Latino/Hispanic

Language

Employment Status

INSURANCE & PHARMACY INFO

Primary Insurance Plan

Subscriber/ID Number

Secondary Insurance Plan

Subscriber/ID Number

Pharmacy

Location of Pharmacy

Secondary Pharmacy

Location of Pharmacy

CONTACT

Home Number

Mobile Number

Work Number

Preferred Phone:
☐ Home ☐ Mobile ☐ Work

Preferred Method:
☐ Voice ☐ Email ☐ Text

Email Address

Mailing Address

City/State

Zip

Physical Address

City/State

Zip

Emergency Contact

Relationship

Phone Number

Parent/Guardian (if patient is a minor)

Relationship

Phone Number

Consent to Treatment

I give permission for ARcare, its clinical subsidiaries and DBAs to give _____ medical treatment.
Patient Name

Date of Birth SSN

Initial ONE:

[ ] I am the patient.

[ ] Patient is a minor who is _____years of age.

[ ] Patient is an adult who cannot act on his or her own.

IF PATIENT IS A MINOR:

I give permission for my child to receive an examination and treatment in the absence of adult supervision.

☐ Yes ☐ No

I give permission for the following individuals (in addition to immediate family members) to bring my child to the clinic on my behalf **(Select at least ONE):**

☐ None ☐ School staff ☐ Clinic staff ☐ Daycare staff ☐ Other (please list):

1. I voluntarily consent to care recommended by the clinician, including, x-rays, heart tracings, screenings and assessments, medications, and/or routine laboratory testing (including human immunodeficiency virus infection, hepatitis, or any other blood-borne infectious disease if ordered by a clinician for diagnostic purposes).
2. I authorize the clinic to release medical/behavioral health information to insurance carriers for the purposes of filing insurance claims related to my/him/her medical care.
3. I agree that insurance (if applicable) will be billed for services and I (patient, parent or guardian of the patient) am responsible for any charges not paid or denied by the insurance company.
4. I understand that even if you have a copy of my Advance Directive or Living Will that clinic staff will attempt to stabilize me and transfer me to an acute care hospital for further evaluation and treatment.
5. I have received the Patient Packet containing ARcare's Notice of Privacy Practices and my rights about my medical information as a patient of ARcare.

COMMENTS:

Signature of patient or adult consenting for a patient Relationship to patient Date

Signature of staff who explained the contents of this consent form Date

Consent to Obtain Medication History

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your “medication history”. A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing the consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose, information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescriptions to treat HIV/AIDS and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.

The medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements, or herbal remedies. It is still very important to us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history.

I give permission for you to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Patient Name	Date of Birth
Signature of patient or adult consenting for a patient	Date

HIPAA Privacy Practices Consent Form

We are committed to providing security for patient privacy and confidentiality. We collect, use, and disclose personal health information only when allowed by state and federal laws and your personal authorization. This may include the collection of other sources of information available, such as medication and prescription history and verification of insurance eligibility.

We also understand you may have family members or significant people in your life who you may want to have access to certain information contained in your medical record. Without your written consent, we cannot release any information to anyone except for purposes outlined in the HIPAA privacy act. ***Please note that we use an automated phone system to remind you of appointments as well as offer patients the opportunity to complete a survey about their visit.***

I give permission for those (employees, students, volunteers, contractors, etc.) acting on behalf of the organization to share my protected health information (PHI) with the following specific person(s): (If no other person is authorized to receive your PHI, write N/A in the spaces below.)

1 **Name of Individual to which information can be released** _____

Information to be released
☐ Copy of complete health record ☐ History and physical ☐ Test results
☐ Mental health records ☐ Reproductive health records ☐ Other_____

2 **Name of Individual to which information can be released** _____

Information to be released
☐ Copy of complete health record ☐ History and physical ☐ Test results
☐ Mental health records ☐ Reproductive health records ☐ Other_____

3 **Name of Individual to which information can be released** _____

Information to be released
☐ Copy of complete health record ☐ History and physical ☐ Test results
☐ Mental health records ☐ Reproductive health records ☐ Other_____

_____
If 12-17 years of age, patient must sign here to acknowledge approval of information to be released.

I GIVE MY PERMISSION TO:

(INITIAL all that apply) MUST INITIAL AT LEAST ONE

___ Leave a message on my answering machine or other electronic device(s) about my appointments, lab results, follow-up care, or other medical information.
___ Contact me at my home address and phone number.
___ Leave a message with the person indicated as a "message" number if I cannot be reached otherwise.
___ Send me an email message at:_____
___ Contact me regarding voluntary participation in clinical research. I understand that by checking this box I am NOT obligated to participate in any specific project.
Please contact me about projects by: ☐ mail ☐ phone ☐ email address

_____ _____
Print Name of Patient Date of Birth

_____ _____
Signature of patient or adult consenting for a patient Date

Financial Obligation Form

I UNDERSTAND THE FOLLOWING:

- I am responsible for any charges that are incurred during my office visit.
- If I have insurance, I am responsible for copays, deductibles and coinsurance.
- If I fail to meet my financial obligations, my account will be sent to a collection agency after 90 days.
- I will have an opportunity to pay on this account, or set up a structured payment plan, before it will be sent to collections.
- I will receive 3 statements before my account will be turned over to collections.
- If I overpay and have a credit, the credit will be applied to other open claim balances. If no open claim balance exists and I have been turned over to a collection agency in the past, an in-house credit will be provided and issuance of a refund check will be deferred for one year.
- Should I be unable to make a payment on my account at this time, I understand that ARcare/KentuckyCare/Mississippicare will see me regardless of my ability to pay.
- Furthermore, the collection policy has been explained to me. I understand that ARcare/Kentuckycare/MississippiCare will see me regardless of my ability to pay.

DISCLAIMER

I agree that the facility, ARcare/ KentuckyCare/MississippiCare, or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") may contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message, to collect any money that I owe to the facility. I understand, acknowledge, and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages, or voicemail messages. I further agree that the collectors may contact me using email at any email address I provide to the facility or is otherwise associated with my account.

_____ _____

Print Patient Name Date of Birth

_____ _____

Patient and/or Guarantor Signature Date

Patient and/or Guarantor Mailing Address:

_____

_____

_____

_____ _____

Staff Witness Signature Date

Household Assessment

(ONLY for patients requesting discounted services)

ARcare/KentuckyCare/MississippiCare offer a discounted fee program (nominal/sliding fee discount) to eligible patients who apply for assistance. The discounts are based on the Federal Poverty Guidelines. Discounts are given up to 200% of the Federal Poverty Level. **Income verification must be provided before discounts will be applied.** Discounts will not be given to households above 200% of the Federal Poverty Level.

The organization's sliding fee scale program has been explained to me.
☐ **I DO wish to participate in this program.**
☐ **I DO NOT wish to participate in this program.** (If you do not wish to participate, stop here.)

Is the Patient Head of Household?
☐ Yes ☐ No If no, who is the head of Household? _____

List all dependents (anyone who resides with you and for whom you have legal, custodial, or financial responsibility.) Please list the **total monthly** gross income for each household member.

NAME	Relationship to Patient	Birth Date	Income

By signing this application, I represent that the information and answers given in this application are true, complete and correctly recorded. If fraudulent misstatements were made, the organization reserves the right to request full payment for services provided to the patient. I understand that any charges for my household that are not covered by the discounted service program are my responsibility for my household and I agree to pay for these charges.

_____ _____

Signature Date

_____ _____

Patient Name Date of Birth

Consent to Telemedicine

1. I authorize ARcare/MississippiCare/KentuckyCare to allow me to participate in a telemedicine/Virtual Care (videoconferencing) service with ARcare. This consent applies to both Physical and Behavioral Health Services.

   If Behavioral Health Services is indicated or requested: I understand that Tele-behavioral health services are completely voluntary and that I can choose not to do or not to answer questions at any time. I understand that I will be assigned one therapist and will only see that that therapist for my behavioral health care via tele-behavioral health services in ensuring continuity of care. I understand that I will be asked to create a safety plan with my therapist in case of an emergency. I understand that if there's an emergency during a Tele-behavioral health session, my therapist will call emergency services and my emergency contacts.

2. The type of service to be provided via telemedicine is Acute Care Services.

3. I understand that this service is not the same as a direct patient/healthcare provider visit, because I will not be in the same room as the healthcare provider performing the service. I understand that parts of my care and treatment which require physical tests or examinations may be conducted by the clinical staff at my location under the direction of the telemedicine healthcare provider.

4. My physician has fully explained to me the nature and purpose of the videoconferencing technology and has also informed me of expected risks, benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise during the telemedicine session, as well as possible alternatives to the proposed sessions, including visits with a physician in-person. The attendant risks of not using telemedicine sessions have also been discussed. I have been given an opportunity to ask questions, and all my questions have been answered fully and satisfactorily.

5. I understand that there are potential risks to the use of this technology, including but not limited to interruptions, unauthorized access by third parties, and technical difficulties. I am aware that either my healthcare provider or I can discontinue the telemedicine service if we believe that the videoconferencing connections are not adequate for the situation.

6. I understand that the telemedicine session will not be audio or video recorded at any time.

7. I agree to permit my healthcare information to be shared with other individuals for the purpose of scheduling and billing. I agree to permit individuals other than my healthcare provider and the remote healthcare provider to be present during my telemedicine service to operate the video equipment. I further understand that I will be informed of their presence during the telemedicine services. I acknowledge that if safety concerns mandate additional persons to be present, then my/guardian permission may not be needed.

8. I acknowledge that I have the right to request the following: a. The omission of specific details of my medical history/physical examination that is personally sensitive, or b. Termination of the service at any time.

9. When the telemedicine service is being used during an emergency, I understand that it is the responsibility of the telemedicine provider to advise my local healthcare provider regarding necessary care and treatment.

10. It is the responsibility of the telemedicine provider to conclude the service upon the termination of the videoconference connection.

11. I understand that my insurance will be billed by both the local healthcare provider and the telemedicine healthcare provider for telemedicine services. I understand that if my insurance does not cover telemedicine services I will be billed directly by the telemedicine healthcare provider for the provision of telemedicine services.

12. My consent to participate in this telemedicine service for the duration of the specific service identified above, or until I revoke my consent in writing.

13. I agree that there have been no guarantees or assurances made about the results of this service.

14. I confirm that I have read and fully understand both the above and the Telemedicine: What to Expect Form provided.

Patient Name	Date of Birth
Signature of patient or adult consenting for a patient	Date