Name: _____ Acct #: _____ Date: _____

CONWAY ORTHOPEDIC & SPORTS MEDICINE CENTER

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____

SSN: _____ Date of Birth: _____ Sex: Male Female

Preferred Language: _____ Race: African American Asian Caucasian Hispanic Native American Other

Ethnicity: Hispanic Non-Hispanic Email Address: _____

Marital Status: Married Single Divorced Widowed

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Number: _____ Cell Number: _____ Work Number: _____

Are you Employed? (circle one) Full-time Part-time Disabled Retired Unemployed

Guarantor Information

First Name: _____ Last Name: _____ Middle Initial: _____

SSN: _____ Date of Birth: _____ Relationship: _____

Preferred Language: _____ Race: African American Asian Caucasian Hispanic Native American Other

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Number: _____ Cell Number: _____ Work Number: _____

Name: _____ Acct #: _____ Date: _____

CONWAY ORTHOPEDIC & SPORTS MEDICINE CENTER

Insurance Information

PRIMARY

Insurance Company: _____ Phone Number: _____

Policy Holder: _____ Policy Holder's DOB: _____ Relationship to patient: _____

Policy Holder's SSN: _____ Policy/ID/Member #: _____ Group #: _____

Medication Insurance if Different: _____

Pharmacy: _____ Pharmacy Address: _____

Insurance Information

SECONDARY

Insurance Company: _____ Phone Number: _____

Policy Holder: _____ Policy Holder's DOB: _____ Relationship to patient: _____

Policy Holder's SSN: _____ Policy/ID/Member #: _____ Group #: _____

Medication Insurance if Different: _____

Pharmacy: _____ Pharmacy Address: _____

Name: _____ Acct #: _____ Date: _____

Right or Left Hand Dominant (circle one)

Height: _____

Weight: _____

CONWAY ORTHOPEDIC & SPORTS MEDICINE CENTER

Allergies

***Please check this box if you have a metal allergy ☐

Please list drug allergies and/or other allergies (in particular seafood, contrast dye, iodine and latex)

1. _____ 3. _____ 5. _____ 7. _____

2. _____ 4. _____ 6. _____ 8. _____

Past Medical History

Please Check if you have ever experienced any of the following conditions, and the year of onset

	Year		Year		Year
☐ None		☐ Asthma		☐ Diabetes (type)	
☐ High Blood Pressure		☐ Allergies		☐ Thyroid Problems	
☐ High Cholesterol		☐ Anemia		☐ COPD	
☐ Heart Attack		☐ Reflux Disease (GERD)		☐ Stroke	
☐ Congestive Heart Failure		☐ Irritable Bowel Syndrome		☐ Other Conditions	
☐ Other Heart Problems		☐ Diverticulosis		☐ Autoimmune Disorder	

☐ Cancer (type) _____

☐ Other: _____

Reason for Visit

What are you being seen for today? _____ Right or Left

Did you have an accident? YES or NO What is the accident related to? ☐ Work ☐ Auto ☐ Other

Please provide a brief description: _____

When did the accident occur (Month, Day, Year): _____ Where did accident occur? _____

Did you go to the emergency room? YES or NO If yes, where/when? _____

Did you have any imaging taken? YES or NO Type (X-ray, MRI): _____

Past Surgical History

Please list any surgeries and/or procedures you have had in the past along with the year it was completed (include biopsies and cesarean section)

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Have you ever had any problems with anesthesia or conscious sedation (such as Demerol, Fentanyl, Versed, or Valium)? Y N

If yes, please explain: _____

Name: _____ Acct #: _____ Date: _____

CONWAY ORTHOPEDIC & SPORTS MEDICINE CENTER

Medications

☐ Check box if you do not take any medications

Pharmacy name and address: _____

Please list all current medications and dosage (please include any over the counter medications, vitamins and/ or herbal you take as well).

	Medication Name	Strength		Medication Name	Strength
1.			8.		
2.			9.		
3.			10.		
4.			11.		
5.			12.		
6.			13.		
7.			14.		

Social History

	Yes	No		
Smoking Tobacco	☐	☐	Packs per day: _____	How Long: _____
Smokeless tobacco	☐	☐	How Much: _____	How Long: _____
Alcohol Use	☐	☐	How Much: _____	
Recreational Drug Use	☐	☐	Type: _____	Needle Use: Yes or No
Blood Transfusions	☐	☐	Year: _____	Reason: _____
Tattoos/Piercings	☐	☐	Date: _____	
Special Diet	☐	☐	Type: _____	
Exercise	☐	☐	Type: _____	
Pets	☐	☐	Type: _____	

Marital status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Occupation: _____

Family History

If any Blood immediate family member has suffered from the following conditions, check the box and indicate which relative (mother, father, maternal grandparent, paternal grandparent etc.)

	Diabetes	Thyroid	Heart Disease	Asthma	Stroke	Cancer	What type?
Mother	☐	☐	☐	☐	☐	☐	_____
Father	☐	☐	☐	☐	☐	☐	_____
Brother or Sister	☐	☐	☐	☐	☐	☐	_____
Children	☐	☐	☐	☐	☐	☐	_____
Maternal Grandparent	☐	☐	☐	☐	☐	☐	_____
Paternal Grandparent	☐	☐	☐	☐	☐	☐	_____

Name: _____ Acct #: _____ Date: _____

CONWAY ORTHOPEDIC & SPORTS MEDICINE CENTER

Medical Provider Information

Primary Care Physician: _____

Phone Number of Primary Care Physician: _____

Referring Physician: _____

Review of Symptoms

Symptoms currently experiencing (check all that apply)

Constitutional
- ☐ Weight Loss, amount lbs. ___
- ☐ Weight gain amount lbs. ___
- ☐ Fever
- ☐ Exercise Tolerance

Eyes
- ☐ Dry Eyes
- ☐ Irritation
- ☐ Visual Changes

ENT
- ☐ Sore Throat
- ☐ Difficulty Hearing
- ☐ Ear Pain
- ☐ Nose Bleeds
- ☐ Sinus Pain
- ☐ Bleeding Gums
- ☐ Snoring
- ☐ Dry Mouth
- ☐ Teeth Problems

Cardiovascular
- ☐ Chest Pain on Exertion
- ☐ Arm Pain with Exertion
- ☐ Shortness of Breath when Walking
- ☐ Shortness of Breath when Lying Down
- ☐ Palpitations
- ☐ Heart Murmur
- ☐ Light Headed when Standing

Respiratory
- ☐ Wheezing
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Coughing Blood
- ☐ Sleep Apnea

Ophthalmology
- ☐ Blued Vision
- ☐ Double Vision

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Vomiting
- ☐ Change in Appetite
- ☐ Black or Tarry Stools
- ☐ Diarrhea
- ☐ Reflux / Heartburn
- ☐ Vomiting Blood
- ☐ GERD

Breast
- ☐ Perform Monthly Self-Breast Exams
- ☐ Yearly Mammograms

Musculoskeletal
- ☐ Muscle Aches
- ☐ Weakness
- ☐ Joint Pain
- ☐ Back Pain
- ☐ Swelling in Extremities

Integumentary
- ☐ Abnormal Mole
- ☐ Jaundice
- ☐ Rash / Itching
- ☐ Dry Skin
- ☐ Growths / Lesions
- ☐ Laceration

Neurology
- ☐ Headache
- ☐ Los of Consciousness
- ☐ Weakness
- ☐ Numbness
- ☐ Seizures

Genitourinary
- ☐ Incontinence
- ☐ Difficulty Urinating
- ☐ Blood in Urine
- ☐ Increased Urinary Frequency
- ☐ Incomplete Emptying

Psychiatric
- ☐ Depression
- ☐ Sleep Changes
- ☐ Restless Sleep
- ☐ Alcohol Abuse

Endocrine
- ☐ Fatigue
- ☐ Increased Thirst
- ☐ Hair Loss
- ☐ Increase Hair Growth
- ☐ Cold Intolerance

Hematologic/Lymphatic
- ☐ Swollen Lymph Nodes
- ☐ Easy Bruising
- ☐ Excessive Bleeding

Allergic/Immunologic
- ☐ Runny Nose
- ☐ Sinus pressure
- ☐ Itching
- ☐ Hives
- ☐ Frequent Sneezing

Name: _____ Acct #: _____ Date: _____

CONWAY ORTHOPEDIC & SPORTS MEDICINE CENTER

Emergency Contact

Person to Notify

Name:_____ Relationship:_____ Phone Number:_____

Next of Kin

Name:_____ Relationship:_____ Phone Number:_____

HIPAA Consent

Release of Information

I do hereby authorize Conway Orthopedic and Sports Medicine Center to release any and all healthcare information including scheduled appointments, clinical chart notes, and financial information to the name/names listed below. I understand that on release of this information, Conway Orthopedic and Sports Medicine Center cannot guarantee confidentiality on behalf of those that received the information.

Name of Person to Release Information	Relationship	Phone Number
Name of Person to Release Information	Relationship	Phone Number
Name of Person to Release Information	Relationship	Phone Number

Signature of Patient OR Guardian (if minor) _____ Date

Name: _____ Acct #: _____ Date: _____

CONWAY ORTHOPEDIC & SPORTS MEDICINE CENTER

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 THIS CAREFULLY.

(If you have any questions about this notice, please contact our Privacy Officer at 2302 College Ave., Conway, AR 72034 or by phone at 501-450-2132.)
This notice describes the information privacy practices followed by our physicians and staff.
This notice applies to the information and records we have about you, your health, health status, and the health care and services you receive from Conway Orthopedic and Sports Medicine Center. Your health information may include information created and received by Conway Orthopedic and Sports Medicine Center, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

- **For treatment**: We may use and disclose health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses' technicians, staff or other personnel who are involved in taking care of you and your health. For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you. Different personnel in our organization may share information about you and disclose information to people who do not work for Conway Orthopedic and Sports Medicine Center. In order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We will request your permission before sharing health information with your family or friends unless you are unable to give permission to such disclosures due to your health condition.
- **For payment**: We may use and disclose health information about you so that the treatment and services you receive at Conway Orthopedic and Sports Medicine Center may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will pay for the treatment.
- **For Health Care Operations**: We may use and disclose health information about you in order to support the business activities of Conway Orthopedic and Sports Medicine Center and make sure that you-and our patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient or whether certain new treatments are effective. We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you, Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care, reduce costs, coordinate and manage health care and services, train staff, and comply with the law.

Special Situations
We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

- **To avert a serious threat to health or safety**: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **Required by law**: We will disclose health information about you when required to do so by federal, state, or local law.

- **Military, Veterans, National Security and Intelligence**: If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

- **Workers Compensation**: We may release health information about you to workers' compensation or similar programs. These programs provide benefits for work related illnesses or injuries.
- **Public Health Risk**: We may disclose health information about you for public health reasons in order to prevent or control diseases, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

- **Health oversight activities**: We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes**: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to. A subpoena.
- **Law Enforcement**: We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons, or similar process, subject to all applicable legal requirements.
  Coroners, Medical Examiners and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

- **Information not Personally Identifiable**: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

- **Family and Friends**: We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgement that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse where you bring your spouse with you into the exam room or hospital during treatment or while treatment is being discussed. In situations where you are not capable of giving consent because you are not present or due to your incapacity or medical emergency, we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's Involvement In your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example fill prescriptions, medical supplies, or x-rays.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may disclose your protected health information to disaster relief organizations that see your protected health information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding your health information we maintain about you:

- **Right to inspect and copy**: You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to our Privacy Official in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include a request to review a summary of your medical record. Lf you request to view a copy of your health information, we will not charge you for inspecting your health information. If you wish to inspect your health information, please submit your request in writing to our Privacy Official. You have a right to request a copy of your health information in electronic form if we store your health information electronically. We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies or access to health information that we keep about you, you may ask that our denial be reviewed. We will select a licensed

health care professional to review your request and our denial. The person conducting the review will not be the person who denied our request, and will comply with the outcome of the review.

- **Right to Amend**: If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by Conway Orthopedic and Sports Medicine Center. To request an amendment, please complete and submit a medical record amendment/correction form to our Privacy Official. We may deny your request for an amendment if your request is not in writing or does not include a reason to support the request, In addition, we may deny your or partially deny your request if you ask us to amend information that:
    a. We did not create, unless the person or entity that created the information is no longer available to make the amendment.
    b. Is not part of the health information that we keep.
    c. You would not be permitted to inspect and copy.
    d. Is accurate and complete.

    If we deny or partially deny your request for amendment, you have the right to submit a rebuttal and request the rebuttal be made a part of your medical record. Your rebuttal needs to be 2 pages in length or less and we have the right to file a rebuttal responding to yours in your medical record. You also have a right to request all documents associated with the amendment request (including rebuttal) be transmitted to any other party any time that portion of the medical records is disclosed.

- **Right to an Accounting of Disclosures**: You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, when specifically authorized by you and a limited number of special circumstances involving national security, correctional institutions and law enforcement. To obtain this list, you must submit your request in writing to our Privacy Official. It must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list. The first list you request in a 12 month period will be free. We may charge you for additional lists.

- **Right to request restrictions**: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like family or friends. For example, you could ask that we not use or disclose information about a surgery you had. We are not required to agree with your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information. We are required to agree with your request if you pay for treatment, services, supplies, or prescriptions out of pocket and you request the information to be communicated to your health plan for payment of health care purposes. There may be instances where we are required to release this information if required by law. To request restrictions, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information to our Privacy Official.

- **Right to request confidential information**: You have the right to request that we communicate with you about medical matters in a certain way or at a certain time or location. For example, you can ask that we only contact you at work or via e-mail. To request confidential communications, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Information to our Privacy Official. We will not ask you the reason for the request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a paper copy of this notice**: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to Paper copy. To obtain such a copy, contact our Privacy Official.

We reserve the right to change this notice and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future.
We will inform you if there is a breach of your unsecured health information. If you believe your privacy rights have been violated, you may file a complaint with our office or the Secretary of the Department of Health and Human Services.
To file a complaint with Conway Orthopedic and Sports Medicine Center contact our Security Official at 501-450-2132 , you will not be penalized 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. If you have any objections to this form, please ask to speak to our HIPAA Compliance Officer in person or by phone at 501-450-2132. Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name	Signature	Date of Signing

Name: _____ Acct #: _____ Date: _____

CONWAY ORTHOPEDIC & SPORTS MEDICINE CENTER

Consent for Treatment, Assignment of Benefits and Release of Information

Patient Name: _____

I, the undersigned, consent to being treated by the **Conway Orthopedic and Sports Medicine Center** physicians, nurse practitioners and/or physician assistants, as is necessary or advisable in their judgment.

I also authorize payment directly to **Conway Orthopedic and Sports Medicine Center** for all medical services provided to me. I understand this assignment and authorization is for all benefits that are payable by any insurance company or third-party payer on my behalf. I understand that I am financially responsible to **Conway Orthopedic and Sports Medicine Center** for all charges not paid by my insurance company or any third-party payer, including all copayments and deductibles. I agree that **Conway Orthopedic and Sports Medicine Center** and its assignees and contractors may take all of the following actions regarding amounts owed to the Clinic: (1) contact me by telephone at any telephone number I provide, (2) leave voicemail or answering machine messages for me, (3) send emails or text messages to any account or number I provide, or (4) use pre-recorded voice messages or an automatic dialing device to contact me.

I also authorize **Conway Orthopedic and Sports Medicine Center** to disclose all or any part of my protected health information to any person or entity which is or may be responsible for any of the Clinic charges for services provided to me. This authorization to disclose information and the assignment of benefits will remain in effect until all charges have been paid that are due to the Clinic.

This authorization to disclose protected health information specifically includes the authorization to disclose any information regarding treatment for a substance abuse disorder, which is protected by Federal law (42 CFR Part 2). Any disclosure of information that is protected by 42 CER Part 2 pursuant to this authorization is only permitted for purposes of payment or healthcare operations and not for purposes of treatment.

I acknowledge that I have received or been offered the Notice of Privacy Practices for Conway Regional Health System and its medical staff.

I acknowledge, by my signature below, that I have read this document and that I am the patient or the patient's personal representative, as indicated below.

Patient Name _____ Patient DOB _____

Patient Signature _____ Date of Signing _____

Personal Representative of Patient _____ Relationship to Patient _____

Name: _____ Acct #: _____ Date: _____

CONWAY ORTHOPEDIC & SPORTS MEDICINE CENTER

Patient Account Financial Policy

This Material is being distributed to let you know how your account with our Clinic will be processed. It is our hope that with this knowledge, the burden of worrying about how you will pay for your medical services will be lessened. Generally, our patients fall into three categories for billing purposes. These categories are as follows:

New Patients: Fees for Medical services are due at time service is rendered. All new patients are expected to pay their full balance at the time of the first visit and any visits occurring in the next 45 days.
Patients with Health Insurance Coverage: Fees for medical services are due at time service is rendered. Our Clinic will file all claims for Medicaid, Medicare, and certain managed care insurances for which we are a participating provider. As a COURTESY to our patients, we can file directly with certain other insurance carriers. Please check with our insurance clerk to see if we can file your insurance claim for you.

The Clinic will accept assignment of qualifying insurance benefits in lieu of payment for a period of 45 days after we have filed the insurance. If your insurance company has not paid on your account within 45 days, the account reverts to SELF PAY status and it will be necessary for you to make arrangements to secure your account. Staying in contact with your insurance carrier while the claim is in process will help to assure that the claim will be processed in a timely manner.

After your insurance has settled their portion of your account, you have an additional 30 days to remit the balance. In order to avoid a hardship, we recommend that you begin making payment on your portion of the bill even before your insurance has paid. Should an overpayment arise, it will be promptly refunded to the appropriate party. Accounts not settled within the prescribed 30 day time frame may be subject to referral to third party collections. Any accounts referred to a third-party collection agency, will be charged an additional 18% to the balance to cover collection agency fees.

Should an insurance payment ever be made directly to you, your balance with the Clinic shall be due in 10 days.

Patients with No Health Insurance Coverage: Fees for medical services are due at time service is rendered. For some clinical services, a pre-paid deposit may be requested.
I acknowledge that I will be charged a $25 fee for failing to keep a scheduled appointment without any prior notice.

Should you have any questions regarding your account at our Clinic, please contact the Office Manager or Insurance Clerk. We will be happy to assist you in anyway.
Thank you for using the services of Conway Orthopedic and Sports Medicine Center.

Print Name	Signature	Date of Signing