Welcome to Apex Family Medical Clinic
New Patient Consent Forms

Please complete the following questionnaire. This will become part of your office record and will be held in strict confidence.

Date _____

Information on Patient

Name:_____
Last First Middle

Sex: Male ☐ Female ☐ Social Security Number: _____-_____-_____
Marital Status _____ Date of Birth _____

Home Address _____
_____
City State Zip

Preferred Phone Numbers (please circle type)
1._____ (cell, home, work)
2._____(cell, home, work)

Email Address _____

Occupation_____

Employer and Phone Number_____/_____

Policy Holder Information

☐ **Check here if this information is the same as patient above.**

Guarantor's Name: _____
Home Address _____
City _____ State _____ ZIP _____
Home Phone _____ Work Phone _____
Date of Birth _____ SS# _____
Employer _____
Relationship to Patient _____

Insurance Information

_____
1st insurance company Policy # Group # Insured 's Name

_____
2nd insurance company Policy # Group# Insured's Name

I agree to be responsible for any charges for services and material supplied by Apex Family Medical Clinic and its doctors for the above patient.

_____
Signature of party responsible for payment Date

Apex Family Medical Clinic

Emergency Contact Person: _____
Phone # _____ Address_____
Relationship to Patient _____

Preferred Pharmacy: _____ Phone # _____
Pharmacy Address _____

How did you hear about us?

□ Word of mouth (friend/family)
□ Yahoo
□ Facebook
□ Drove by
□ Our website
□ Television
□ Google
□ Radio
□ Other_____

Apex Family Medical Clinic

Notice of Privacy Practices Acknowledgment Form HIPAA

I acknowledge that I have received a copy of the Apex Family Medical Clinic Notice of Privacy Practices and have had an opportunity to review it. I have also been given an opportunity to request restriction on the use and disclosure of my protected health information, as well as to request confidential treatment of communications relating to my health information.

_____

Signature of patient Date

I choose to designate the individuals listed below as my primary contacts. Apex Family Medical Clinic personnel may share information with these primary contacts that is consistent with the Notice of Privacy Practices.
Patient's Name _____ Patient's DOB _____
Contact Name _____ Relationship _____
Contact phone # _____
Contact Name _____ Relationship _____
Contact phone # _____
Signature: _____ Date _____
Relationship_____
(Patient, parent, authorized representatives)

If you would like your own personal copy of our HIPPA policy, please see someone at the front desk.

Apex Family Medical Clinic

Consent for Purposes of Treatment, Payment, and Health Care Operations.

I understand that, as a condition to my receiving treatment from Apex Family Medical Clinic, Apex Family Medical Clinic may use or disclose my personally identified health information for treatment to obtain payment for the treatment provided and as otherwise necessary for the operations of Apex Family Medical Clinic. These uses and disclosures are more fully explained in the Notice of Privacy Practices that has been provided to and reviewed by me.

While I am here, I permit the employees, the doctor and all other persons caring for me to treat me in ways the judge are beneficial to me. I understand the attending physician will explain to me the nature of my condition, his or her will explain to me other ways this condition could be treated. I further understand that this care may include diagnostic testing, examinations, medical and/or surgical treatment, and that no guarantees have been made to me about the outcome of this care.

"Personally identifiable health information" refers to health and demographic information collected about me by my physician (or other health care provider, public health authority, health plan, employer, life insurer, school or university, or health care clearing house) that relates to my past, present or future physical or mental health or condition or payment for provision of health care. The information identifies me, or there is a reasonable basis to believe that in information ma identify me.

I understand that privacy practices described in the Notice of Privacy Practices may change over time and that I have the right to obtain any revised Privacy Notice by contacting Apex Family Medical Clinic to make such a request. I may receive a revised copy of the Notice of Privacy Practices by calling the office and requesting it to be mailed or by asking for on at my next visit.

I also understand that I have the right to request Apex Family Medical Clinic to restrict how my health information is used or disclosed. Apex Family Medical Clinic does not have to agree to my request for the restriction, but if Apex Family Medical Clinic does agree, Apex Family Medical Clinic is bound to abide by the restriction as agreed.

Finally, I understand that I have the right to revoke/withdraw this consent, in writing, at any time. My revocation/withdrawal will be effective except to the extent that Apex Family Medical Clinic has taken action in reliance on my consent for use or disclosure of my health information, Provision of future treatment may be withdrawn if I withdraw my consent.

_____

Signature Date

Financial Policy

Thank you for choosing Apex Family Medical Clinic as your healthcare provider. We are committed to quality patient care at the lowest possible cost. The following is a statement of our financial policy that we require you to read and sign prior to any services being rendered.

Please be aware that some, and perhaps all. Of the services provided may be noncovered services that are not considered reasonable and necessary by you insurance carrier.

Participating insurance plans:
For those plans with which we are participating providers, all co-pays and deductibles are due at the time of service. To properly bill you insurance company and avoid untimely delays, we require that you provide us with accurate insurance information and allow us to maintain a copy of your insurance card on file. In the event that your insurance coverage changes to plan with which we do not participate, refer to the follow in paragraph.

Nonparticipating plans:
For those plans with which we do not participate, we do not accept assignment of insurance benefits and we do not bill you insurance company. Payment by cash, check, or charge (VISA or MasterCard) is expected at the time of service. Your Policy is a contract between you and your insurance company.

Minors:
A minor must be accompanied by a guarantor for his or her account (the parent or guardian of the minor or other adult accompanying the minor during each visit). An unaccompanied minor will be denied non-emergency treatment unless charges have been pre-authorized to an approved credit plan or insurance plan.

Authorization to pay benefits to physician/clinic:
I hereby assign payment directly to Apex Family Medical Clinic for medical and/or surgical benefits, if any, otherwise payable to me for services provided at the clinic (not to exceed my indebtedness to the clinic for those services). I understand that I am financially responsible for charges not covered by my insurance.

Authorization to release information:
I hereby authorize Apex Family Medical Clinic to release any information acquired in the course of my examination or treatment to my referring physician and /or insurance company.

Acknowledgement:
I have read and understand the above Financial Policy and Benefit Authorization and agree to all provisions outlined herein.

_____

Signature of patient or responsible party Date

Missed Appointment Policy

Our goal is to provide quality medical care in a timely manner. No shows, late shows, and cancellations make this more difficult to achieve. We would like to remind you of our policy regarding missed appointments.

Cancellation of an Appointment.

In order to be respectful of the medical needs of other patients, please be courteous and call Dr. Gaston's office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel you scheduled appointment, we require that you call within 24 hours.

Late Cancellations

A cancellation is considered to be late when the appointment is cancelled within 24 hour advance notice.

No Show Policy

A "No Show", is a patient who misses an appointment without cancelling it. A failure to be present at the time of a scheduled appointment will be recorded in the patients chart as a "No Show". **This includes arriving 15 minutes after your scheduled appointment.**

- 1st "no show", late cancellation, or cancellation without reasonable excuse there will be no charge to the patient.
- 2nd occurrence will result in a fee of $25.00.
- 3rd occurrence will result in a fee of $25.00 and the patient may be discharged from the practice.

Signature:_____ Date:_____

Relationship to patient:_____

Medical Records Release

To ensure that your medical records are held in the utmost confidentiality, please be as explicit as possible as to where you want them sent.

1. I hereby authorize the release of information from the medical records of:

Name _____

Address_____
Street City State Zip
Home phone _____ Work phone _____

Date of Birth _____

2. Please transfer my medical records as follows:

From: _____ To: _____
_____ _____
_____ _____
_____ _____

3. Records to be released:
____ Annual exams ____ Lab/X-ray/Radiology ____All Medical Records
____ Other _____

4. Purpose of Disclosure:
__Continuing Medical Care __Motor Vehicle or other Accident __ Legal Purpose __Insurance
__Workers Comp/work related injury __Social Security/Disability __ Other_____

5. I, the undersigned, hereby authorize and consent to the inspection, copying and disclosure by the above named facility to the above-named company or persons, their representative agents, or to the bearer of this instrument of any and all information, records documents, reports, clinical abstracts, histories and charts of every kind and description, including:

Drug and/or alcohol abuse, diagnosis or treatment, HIV/AIDS testing and/or treatment, Psychiatric care and/or mental illness, Confirmed STD test results and/or treatment, relating to the above-named patient's condition, care, confinement and/or treatment.
_____(initials)

6. I hereby release the physicial and the hospital from all legal responsibility or liability that may arise from this act I have authorized.

7. Fees/charges comply with all laws and regulations applicable to release of information. Per Arkansas regulations, I agree to a copy fee of $0.50 each page for the first 25 pages, and $0.25 per page thereafter for copies of the medical record mailed to patients or personal representative.

This consent can be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 60 days.

_____ _____
Signature Date

_____ _____
Witness Interpreter, if necessary