FirstCare Family Doctors
A MANA Clinic

PATIENT REGISTRATION FORM FOR CHILD

Internal Use Only
_____

mana medical associates

PATIENT INFORMATION – Please Print

Patient's Legal Name_____Preferred name: _____ Date _____

Sex: ☐M ☐F Date of Birth _____ Social Security #_____

Allergies_____

Race: ☐ White ☐ African American ☐ Asian ☐ Native Hawaiian/Other Pacific Islander

☐ Native American Indian/ Alaskan ☐ Other Race _____

Ethnicity (Origin): ☐ Not Hispanic or Latino ☐ Hispanic or Latino Preferred (Primary) Language: _____

Sibling _____ DOB_____ Sibling _____ DOB_____

Sibling _____ DOB_____ Sibling _____ DOB_____

Primary Physician _____

Preferred Pharmacy_____ Street_____

Appointment Reminder: Please select how you would like to be notified of your appointment. You may select more than one option. ☐ Email ☐ Text ☐ Phone call

Message and data rates may apply for text messages. To change your preferences at anytime, you may fill out an Appointment Reminder form at the receptionist desk.

PERSON RESPONSIBLE FOR PAYMENT

GUARDIAN(S) / FOSTER PARENT(S): Please complete the parent information and indicate that the child is in your custody.

Responsible Party _____

Address_____ Apt _____ City_____ State____ Zip_____

Home Phone _____ Mobile _____

Father's Name _____ DOB _____ SS# _____

Employer _____ Work Phone _____

Mother's Name _____ DOB _____ SS# _____

Employer _____ Work Phone _____

Please check one: ☐ Married ☐ Single ☐ Partner ☐ Divorced ☐ Widowed ☐ Separated

EMAIL AUTHORIZATION

Email Address _____

By providing my email address above, I hereby agree to allow MANA to contact me by email with e-newsletters, wellness reminders, health news and updates regarding health-related services provided by MANA. I understand that MANA will not share the information provided above with outside marketing companies.

EMERGENCY CONTACT INFORMATION

Relative or Friend not in the home

Emergency Contact _____ Relationship to Patient _____

Phone_____ Address_____ City_____ State__ Zip_____

➔➔ **Please complete the BACK of the form** ➔➔

HEALTH INSURANCE INFORMATION

Please provide a copy of your insurance card to the receptionist.

ARKids First or MEDICAID ☐ No. _____ Effective Date _____

PRIMARY INSURANCE _____

ID#_____ GP#_____ Phone#_____

Address_____ City_____ State_____ Zip_____

Policy Holder's Name _____ DOB_____ SS#_____

Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Other

SECONDARY INSURANCE _____

ID#_____ GP#_____ Phone#_____

Address_____ City_____ State_____ Zip_____

Policy Holder's Name _____ DOB_____ SS#_____

Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Step-Child ☐ Other

INSURANCE AUTHORIZATION AND / OR FINANCIAL AGREEMENT

I hereby authorize Medical Associates of Northwest Arkansas (MANA) to give my insurance company or companies all information they may require concerning my case, and I hereby assign to the physician(s) all payments for medical services rendered.

I understand that I am responsible for any amount not covered by insurance. I agree to pay any co-pay and amount due at the time of service.

Signed_____ Date_____

PATIENT NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received a copy of the Patient Notice of Privacy Practices from Medical Associates of Northwest Arkansas.

SIGNATURE_____ **DATE** _____

In the event this Acknowledgement form is being executed by a personal representative, guardian or parent, please print your name, date of birth, social security number and relationship to the patient here:

_____

If you would like to authorize MANA clinic to release information to a **family member, spouse, or personal representative**, please complete an **Individual Authorization Form** provided by the receptionist.

HOW DID YOU HEAR ABOUT US?

01 ☐ Recommended by a friend or family member.
02 ☐ Clinic web site, www.mana.md
03 ☐ Other web site _____
04 ☐ E-mail, Facebook or Twitter
05 ☐ Signs or location
06 ☐ Kids Directory Magazine
07 ☐ My employer
08 ☐ Citiscapes Magazine
09 ☐ Newspaper
10 ☐ Yellow Pages / phone directory
11 ☐ Received a postcard in the mail.
12 ☐ Referred by Doctor _____
13 ☐ Found the doctor listed in my Insurance directory.
14 ☐ Other *Please specify*_____

Thank you for choosing a MANA Clinic.

FirstCare Family Doctors
A MANA Clinic

CHILD HEALTH HISTORY

ww.mana.md

mana medical associates

Office Use

Child's Name_____Birthdate_____ Today's Date_____

Your child's overall health, as well as any medications your child takes could have an important interrelationship with the care your child receives. Please answer each of the following questions completely.

SOCIAL INFORMATION

Please circle "yes" to any problems your child currently has or has ever had.

Thumb Sucking	Y	N	Developmental Delays	Y	N
Toilet Training Problems	Y	N	Alcohol/Drug Abuse	Y	N
Diarrhea or Constipation	Y	N	Nightmares/Sleep Problems	Y	N
Dental Problems	Y	N	Feeding/Eating Problems	Y	N
Irritable/Temper Problems	Y	N	# of Meals each Day_____# of Snacks_____	Y	N
Bed Wetting	Y	N	Does your child take vitamins or fluoride?	Y	N
Eye Problems	Y	N	Does your child take iron other supplements?	Y	N
Speech Problems	Y	N	Has your child ever eaten dirt, paint or plaster?	Y	N
Hearing Problems	Y	N	Does your child get along well with other children?	Y	N
Emotional Problems	Y	N	Is your child doing well in school?	Y	N
Discipline Problems	Y	N	Is your water fluoridated?	Y	N

PREGNANCY/BIRTH HISTORY

Child's birth weight _____ Delivery: ☐ Vaginal ☐ C-section (elective or emergency)

Was your child born more than two weeks early or late? ☐ Yes ☐ No

Was your child breastfed? ☐ Yes ☐ No Age discontinued_____

Did the mother use cigarettes, alcohol,drugs or medications during pregnancy? ☐ Yes ☐ No

PAST MEDICAL/SURGICAL HISTORY

Has you child ever had? Please circle Yes or No

Mumps/Measles	Y	N	Abnormal Bleeding	Y	N	Sexually Transmitted Disease	Y	N
Chicken Pox	Y	N	Allergies	Y	N	Eczema/Skin problems	Y	N
High Cholesterol	Y	N	Frequent Ear Infections	Y	N	Handicaps/Disabilities	Y	N
Pneumonia	Y	N	Frequent Cold	Y	N	Diabetes	Y	N
Asthma/Wheezing	Y	N	Frequent Sore Throat	Y	N	Rheumatic Fever	Y	N
Cancer	Y	N	Croup	Y	N	Congenital Heart Defect	Y	N
Hepatitis	Y	N	TB/Lung Disease	Y	N	Heart Murmur	Y	N
HIV/AIDS	Y	N	Kidney/Bladder Infections	Y	N	Convulsions/Epilepsy	Y	N
Hemophilia	Y	N	Emotional Disorder	Y	N	Suicide Attempts	Y	N

OVER

PAST MEDICAL/SURGICAL HISTORY (continued)

Please explain any medical problems that your child has had _____

_____

Please list any hospitalizations, serious or unusual illness which your child has experienced.

Date	Hospitalization/Illness	Hospital/Physician	City/State
_____	_____	_____	_____
_____	_____	_____	_____

MEDICATIONS Please list all medications your child currently takes.

Date	Medications/Strength	Frequency	Condition
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES Please list all allergies, sensitivities, and/or reactions to any drugs.

_____

_____

FAMILY HEALTH HISTORY

Name	Age	State of Health	Age at Death	Health Conditions
Father:				
Mother:				
Siblings:				

Mark any diseases known to have occurred in the family with the appropriate initial: (**M**) Mother, (**F**) Father, **GM** (grandmother), **GF** (grandfather), **A** (aunt), **U** (uncle), **C** (cousin), **B** (brother), **S** (sister).

_____ Alzheimer
_____ Asthma
_____ Alcoholism
_____ Blood Disease
_____ Coronary Artery Disease
_____ Cancer
_____ Cholesterol
_____ Stroke
_____ Depression
_____ Developmental Problems
_____ Diabetes
_____ Hearing Prob.
_____ High Blood Pressure
_____ Mental Disease
_____ Migraines
_____ Obesity
_____ Blood Clots
_____ Kidney Prob.
_____ Seizures
_____ Sickle Cel

PHARMACY INFORMATION

Preferred Pharmacy_____ Street_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the doctor's office of any changes in my child's medical status. I also authorize the healthcare staff to perform the necessary services my child needs.

_____ _____
Signature of parent/guardian Date

Office Use

Patient Notice of Our Privacy Practices

Please review the following notice that describes how medical information about you may be used and disclosed and how you may get access to this information.

This is Medical Associates of Northwest Arkansas' ("Clinic's") notice to you of how certain health information regarding you may be used or disclosed by this Clinic. We are required by law to provide you with a description of our privacy practices. Should you have any questions concerning this Notice contact the Privacy Officer named below:

- The effective date of this Notice is April, 2003. You will be provided, either by mail or in person with a copy of any amendments or changes to this Notice.
- This Notice should be delivered to you no later than the date of the first encounter with you as a patient or, in an emergency situation, as soon as possible after the emergency treatment situation.
- This Clinic is required by law to maintain the privacy of your protected health information and to provide you with a notice of our legal duties and privacy practices with respect to your protected health information.
- Should you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer or with the Secretary of Health and Human Services at the address set forth below. Complaints should be in writing with a description of the events under which you believe your privacy rights were violated. Please give us as much detail as possible in your complaint. This will help us investigate your complaint. It is our policy not to retaliate against any patient for filing a complaint involving a violation of their privacy rights.

Privacy Practices

Disclosure of Your Health Information by Us

We may use or disclose your protected health information for purposes of treatment, payment or healthcare operations without your consent or authorization. This information may be transmitted by electronic transmission, by fax transmittal or by e-mail.

Treatment "Treatment" is defined by the Department of Health and Human Services in its Privacy Standards as ". . . provisions, coordination, or management of health care or related services by one or more health care providers. . .". This means that for our own purposes we may use or disclose protected health care information among our employees and other staff professionals of the Clinic for the purpose of treating your medical condition. Furthermore, we may disclose your protected health information to other health care providers if we make a referral or if we seek consultation or review by another health care provider. An example of treatment might include a situation where your treating physician orders blood work or other types of diagnostic tests. The results of these tests might be reviewed by different professionals or caregivers and their conclusions would be used to assist in determining the appropriate therapies or plan of care for your treatment.

Payment "Payment" is a rather broad term. An example of a "disclosure or use of protected health care information" for payment purposes would be submitting a claim to your insurance carrier so as to be reimbursed for our services. Other examples include activities such as determining eligibility of coverage under your insurance plan or answering questions by your insurance company so as to determine whether there was a medical necessity for the procedure or diagnosis performed by us or at our direction.

Health Care Operations The final category under which we may use or disclose your protected health information without your permission is for "health care operations". This category includes a wide range of day-to-day activities performed by us such as quality assessment, case management and care coordination, contacting other providers about care alternatives for you, conducting internal training programs for supervisory purposes, and activities associated with the licensing and issuance of credentials for our staff.

Our Contacts with You

Periodically, we will issue appointment reminders, provide follow-up information on treatment alternatives, and possibly offer other treatment-related services to you. Typically, we conduct these contacts by mail and telephone. If you do NOT wish us to leave messages on your telephone answering machine or to receive mail at your residence, contact us. You do have the right to ask us to contact you in a confidential manner and we will do our best to accommodate you.

Disclosure to Others

You will be asked to sign an authorization if you wish us to disclose your protected health information to others and the disclosure is for something other than payment, treatment or health care operations. You will always have the right to revoke an authorization at any time, except to the extent this Clinic or any other providers have already taken an action in reliance upon your authorization.

Disclosures Without Your Consent or Authorization Under Arkansas law, there are specific conditions or events that must be disclosed to third parties or state agencies whether or not you authorize this use or disclosure. These categories include:

(a) Incidents of suspected child abuse;
(b) Reyes Syndrome;
(c) AIDS or HIV;
(d) Sexual assaults;
(e) Knife or gunshot wounds;
(f) Domestic Violence; and
(g) Sudden death of child.

In addition, Clinic participates in clinical research studies, which may involve your treatment. From time to time, we review our patients' protected health information to determine if they are suitable candidates to participate in clinical research trials. Before we will enroll you in such a research program or disclose your protected health information to third parties conducting clinical research trials, we will obtain your express authorization. Your authorization, will, among other things, contain:

(a) A description of the extent to which your protected health information will be used or disclosed to other persons; and
(b) A description of any protected health information that will not be used or disclosed for purposes of or use in the clinical research trial.

As with any other authorization, you may revoke this authorization at any time and ask that your protected health information no longer be used as part of the clinical research trials.

Patient Individual Rights

You have the following rights which may be exercised by you at any time:

(a) The right to request restrictions on certain use and disclosure of your protected health information. However, please note that we will not be required to agree to these restrictions, particularly if, in our opinion, they interfere with treatment, payment, or other health care operations. However, we are willing to work with you in good faith to implement any restrictions you request. Should we disagree with the restrictions you place upon us, we will notify you in writing and suggest alternatives including seeking another health care provider.
(b) You have the right to receive communications from us in a confidential manner as noted above.
(c) You have the right to inspect a copy of your health information in our file at any time.
(d) You have the right to amend incorrect or incomplete information or to provide a statement as to the reasons you believe the amendment regarding incorrect or incomplete information should be included in your file. However, we are not able to amend or alter health information about you we receive from another health care provider.
(e) You have the right to receive an accounting from us of all disclosures of your protected health information made to third parties other than for treatment, payment, or health care operations purposes. However, this accounting will be subject to certain restrictions and limitations as set forth below.

Restrictions with Regard to Accounting

Your right to an accounting will not include the matters set forth below. An accounting with regard to your personal health information will **NOT** include the following items:

- Internal use by us of your information for treatment, payment or health care operations purchases.
- Disclosures made to you by us or at your request (or the request of your personal representative) to third parties.
- Disclosures made by you to our answering service or directory service when you contacted us after hours.
- Disclosures made to family members or friends in the course of providing care to you.
- Disclosures to correctional institutions.
- Disclosures made by us for law enforcement, national security, or intelligence purposes if the requesting officer asks for non-disclosure by us for a specified period of time.
- Disclosures made to the Department of Health and Human Services, if you have filed a complaint with that organization believing that your privacy rights have been violated.
- Your right to receive a paper copy of this Notice, even if you have previously agreed to receive this Notice electronically.

Questions & Concerns

For more information or to file an internal complaint, contact the Privacy Officer.

Privacy Officer
3383 N. MANA Court, Suite 201
Fayetteville, AR 72703
Phone: (479) 571-6780
Fax: (479) 571-6770

The Privacy Officer listed above can provide you with the appropriate address for the United States Department of Health & Human Services.