HEALTHY CONNECTIONS

**Today's Date**_________________

**Patient Registration Form**

SSN:_____________________________ DOB:_____________________________________

**First Name**________________________ **MI**____ **Last Name**_________________________

**Sex**: ☐ M ☐ F **E-Mail**: ____________________________________________________

**Address**: _____________________________ **City**: ________________ **State/Zip**: _________

**Home Phone**: ________________________ **Cell Phone**: _______________________________

**Work Phone**: ________________ **Other Phone (list whose phone)**: _____________________

**Marital Status**: ☐ M ☐ S ☐ D **Student**: ☐ FT ☐ PT ☐ NO

**Veteran Status** ☐Yes ☐ No

**Employment:** ☐ Full Time ☐ Part Time ☐Unemployed ☐ Retired

**Patient employed by:**________________________ **Occupation:**________________________

**Employer Address:**_________________________ **Employer Phone:**____________________

**Spouse's Name**______________________ **Spouse's Employer** _________________________

**Language**: ☐ English ☐ Spanish ☐Other___________________________________________

**Race:** ☐ African American ☐ Asian ☐ Native American ☐ Native Hawaiian ☐ Pacific Islander ☐ White

**Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino

**You may be eligible for a discount on your medical or dental charges. Please ask to speak with the Financial Counselor for assistance.**

**Guarantor Information** (If under the age of 18)

**SSN**:_______________________________

**First Name**_________________________ **MI**____ **Last Name**_________________________

**DOB**:______________________ **Primary Care Physican**: _____________________________

**Address**: __________________________ **City**: ____________________ **State/Zip**: _________

**Home Phone**: _________________________ **Work Phone**: ____________________________

**Employer:**_____________________________ **Employer Address:**______________________

---

**Emergency Contact**:________________________ **Relation:**____________________________

**Phone**:__________________________________ **This is a:** ☐ Home ☐ Work ☐ Cell Phone

**Does contact reside with patient?** ☐ Yes ☐ No **If no, please list address:**___________________________

_____________________________________________________________________________

---

**Insurance Policy Holders Name:**_______________________________________________

**Relationship to Patient:**_____________________________________________________

**SSN:**________________________ **DOB:**_______________ **Phone:** ____________________

HEALTHY CONNECTIONS

# CONSENT TO TREATMENT

I, ________________________________, voluntarily consent to outpatient care involving routine diagnostic procedures, examination, medical treatment including those procedures deemed medically appropriate by Healthy Connections, Inc. providers.

I authorize the clinic to release information to insurance carriers to process claims and authorize payment of medical benefits to the undersigned physician or supplier for services described below. I further authorize release of medical information to my medical providers or anyone I designate in writing. This Consent to Treatment remains in effect until I revoke in writing.

HIPAA Confirmation: I have had the opportunity to read and understand the Health Insurance Portability and Accountability Act policies in use by Healthy Connections, Inc.

PHOTOGRAPH: I hereby consent Healthy Connections, Inc. to photograph me (or my minor child) and relieve HCI of any responsibility for the use of my photograph for treatment, identification, and education purposes only.

ASSIGNMENT & RELEASE: I agree to assign directly to Healthy Connections, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the attending medical providers to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I understand that this consent form will valid and remain in effect as long as I (he/she) attend the clinic. This form has been fully explained to me and I understand its contents.

________________________________________ ________________

Patient Signature Date

________________________________________ ________________

Parent and/or Guardian Signature for Minor Child Date

___ I understand that if my child is receiving treatment, I am signing this form on their behalf. As the responsible party of a minor child, I am consenting for my child to receive treatment at this clinic.

# NOTICE OF PRIVACY PRACTICES

HEALTHY CONNECTIONS

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF **YOUR** HEALTH INFORMATION IS IMPORTANT TO US!

## OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice of Privacy Practices at any time, including any revisions of the Notices of Privacy Practices. For more information about our privacy practices, or for additional copies of this Notices, please contact us using the information listed below.

**Healthy Connections, Inc., 136 Health Park Drive, Mena, AR. 71953**

Uses and Disclosures of Health Information: We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

- Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
- Payment: We may use and disclose your health information to obtain payment for services we provide to you.
- Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
- Your Authorization: In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
- To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
- Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care; of your location, your general condition, or death. In the event of your incapacity or emergency circumstances, we will disclose health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

- Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
- Required by Law: We may use or disclose your health information when we are required to do so by law.
- Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose your health information to authorized federal officials when required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.
- Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

---

Patient Rights

- Access: You have the right to look at or obtain copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed on this Notice. We will charge you a reasonable cost-based fee for expenses such as copies. You may also request access by sending a letter to the address listed below. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format.
- Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14th, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
- Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **You must make your request in writing.** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
- Amendment: You have the right to request that we amend your health information. **Your request must be in writing, and it must explain why the information should be amended.** We may deny your request under certain circumstances.

---

**I have received and/or reviewed a copy of the Notice of Privacy Practices.**

Patient Name:______________________________

Date:________________________________

Guarantor's Signature:______________________

Date:________________________________

I appoint the following individual(s) to act as my healthcare representative with whom my health information may be disclosed.

Name:______________________________

Relationship:______________________________

Name:______________________________

Relationship:______________________________

Name:______________________________

Relationship:______________________________

You have the right to make changes in writing to this acknowledgement. You have the right to refuse to sign this acknowledgement. If you refuse to sign this acknowledgement we may be forced to refuse to administer treatment based on our inability to properly file your insurance and/or seek medical/dental/mental healthcare consultation and referral services.

HEALTHY CONNECTIONS

# MEMBER RIGHTS & RESPONSIBILITIES

## Member Rights:

1. You have a right to considerate and respectful treatment, regardless of race, creed, color, sexual orientation, national origin, disability, sex, religious preference, marital status, political beliefs, age or insurance status, in a manner showing dignity and respect regarding your personal values and belief systems.
2. You have a right to be seen at a time as close to your appointment as possible with the understanding that the needs of other patients will also be considered.
3. You have a right to seek care at Community Health Centers (CHC) and your payment will be based upon a sliding fee scale or other program eligibility.
4. You have a right to examine and to receive and explanation of your bill, regardless of the source of payment.
5. You have a right to have all physical examinations, interviews, and discussions take place privately and to have all communications and records about your care handled confidentially.
6. You have a right to know the names and the level of training of the providers who take care of you.
7. You have a right to the understandable explanation of what is wrong with you, the tests and treatments that are planned, and the risks involved in those tests and treatments.
8. You have a right to ask for another CHC provider's opinion or to ask that a new provider take charge of your case on a one-time basis.
9. You have a right to offer concerns or complaints about the health care received. Please ask for the Clinical Team Manager in the center.
10. You have a right to know that CHC does not perform any illegal forms of treatment.
11. You have a right to be informed about your treatment, diagnosis, and prognosis, and to accept or refuse health care advice or treatment.
12. You have a right to plan in advance for your health care and treatment, and to choose someone to make decisions for you, to the extent permitted by law, in case you become unable to make them for yourself.
13. You have a right to be informed of any clinical experimentation or other research/educational projects affecting your treatment and to refuse participation in such a experimentation or research.
14. You have the right to a timely response to your reports of pain and to have a clinically appropriate pain relief plan included in your health care plan.

## Member Responsibilities

1. You are responsible for conduct appropriate in a health care center. You may not verbally or physically abuse CHC personnel or property.
2. You are responsible for keeping your appointment at CHC, or notifying CHC in advance if you are unable to come to your appointment.
3. You have the responsibility to provide accurate proof of your financial situation and to meet program requirements.
4. You have the responsibility to pay your portion of charges at the time of service.
5. You are responsible for questioning your provider about anything you do not understand about your care.
6. You are responsible for giving, to the best of your knowledge, accurate and complete information about complaints, past illnesses, medications, hospitalization and other matters relating to health care.
7. You are responsible for following the instructions given to you by your health care provider. You are responsible for the consequences of your own actions if you fail to follow these instructions, or if you refuse treatment.
8. You are responsible for telling your health care provider when you are in pain and join in your pain relief plan.