Paragould
DOCTORS CLINIC

4000 Linwood Drive Suite A Paragould, AR 72450
Phone: (870) 239-8503 Fax: (870) 236-1947

Patient Registration (Please Complete ALL Forms)

Date: _____ **Account Number:** _____

Name: (Last) _____ (First) _____ (Middle) _____

Mailing Address: _____

Physical Address: _____

City: _____ State: ____ ZIP: _____

Birth Date: _____ Soc. Sec. No: _____ Sex: M F

Legal Mother's Name: _____ Legal Father's Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Contact By: Phone Mail Email

Emergency Contact: (Name) _____ (Phone) _____ (Relationship) _____

Local Pharmacy: _____ Town: _____

Preferred Language: _____ Level of Education: _____

Marital Status: Married Single Widowed

Do you smoke?: No Yes If so, how many packs per day?_____ How many years?_____

Race: White Black Asian Pacific Islander Multi-Racial Hispanic Other: _____

Responsible Party if under 18 yrs of age: Self Spouse Parent Guardian

Name: (Last) _____ (First) _____ (Middle) _____

Address: _____

City: _____ State: ____ ZIP: _____

Birth Date: _____ Soc. Sec. No: _____ Sex: M F

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Contact By: Phone Mail Email

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If you have any other insurance policies, please ask the receptionist for an additional form.

Please present your insurance cards to the receptionist.

I authorize the release of all information of any kind that you may have regarding me, including but not limited to, all medical and other records, reports, bill, and other information of any kind. This authorization also specifically authorizes the release of any such information regarding drugs, alcohol, or H.I.V. I authorize the release of medical information necessary to process claims filed on my behalf.

A photocopy of this medical authorization shall be as effective as the original. This authorization is valid for 18 months from the date hereof.

X_____ **X**_____

Patient's/Guardian's Signature **Insured's Signature**

_____

Date

I authorize payment of medical benefits to be made directly to the supplier or provider of services performed. This authorization is valid for 18 months from the date hereof.

X_____ **X**_____

Patient's /Guardian's Signature **Insured's Signature**

_____

Date

Paragould DOCTORS CLINIC

Doctors Health Group Inc. d/b/a Paragould Doctors Clinic
Preliminary Medicare Secondary Payer Questionnaire

Please answer the following questions:

If you are a Medicare patient and the answer to any of the questions below is "yes," please proceed no further and fill out the detailed Medicare Secondary Payer Questionnaire.

1. Are you receiving Black Lung benefits: Yes _____ No _____
2. Is today's visit due to a work-related accident? Yes _____ No _____
3. Is today's visit due to a non-work-related accident? Yes _____ No _____
4. Are you or your spouse currently employed? Yes _____ No _____
5. Do you have group health plan coverage? Yes _____ No _____
6. Do you qualify for Medicare due to End-Stage Renal Disease? Yes _____ No _____

Patient Signature: _____ Date:

Guarantor Signature: _____ Date:

If other than guarantor, relationship to patient: _____

SPOC4547

St. Bernards MEDICAL CENTER
The Heart of Great Medicine

CONDITIONS OF TREATMENT

☐ **USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION/MANDATORY REPORTING**: I have been informed of my rights to privacy in the use and disclosure of my protected health information as it relates to treatment, payment, or healthcare operations as documented in the Privacy Notice. I understand that my protected health information may be released without authorization as needed for treatment, payment, or healthcare operations.

☐ **TITLE VII COMPLIANCE POLICIES**: St. Bernard's Hospital, Inc. d/b/a St. Bernards Medical Center including its various departments ("St. Bernards") is an equal opportunity employer that adheres to all state and federal anti-discrimination laws. Employment related decisions are made without regard to an individual's race, religion, color, national origin, sex, age, disability, veteran status, or any other category protected under state or federal laws.

☐ **GENERAL CONSENT TO TREATMENT AND TESTS**: I desire to receive treatment from St. Bernards. I consent to the rendering of medical services as considered necessary and appropriate by my physician, or any medical practitioner with staff privileges at St. Bernards who has requested medical treatment/services on my behalf. I understand that medical services/treatment may be performed by physicians, nurses, technologists, technicians, physician assistants or other healthcare professionals. I understand that such treatment may take place through telemedicine video conferences. I understand that St. Bernards is a teaching hospital and I hereby authorize residents, students and others in the training program(s) to be involved in my medical care and treatment under the supervision of a qualified medical professional. I permit St. Bernards and its employees and others involved in my care, to treat in the ways they judge to be beneficial to me. I understand that I have the right to ask questions and receive information about my care, treatment, and any medical advice. I understand that some treatment areas and patient rooms are equipped with video surveillance equipment or electronic monitoring devices, which may be used in some circumstances for internal purposes (e.g., identification, diagnosis, treatment, education, safety, security) and authorize the use of either in the sole discretion of St. Bernards. I consent to examinations, x-rays, blood tests, laboratory procedures, medications, anesthesia, surgical treatment, and other medical services or treatments, including photographic/video documentation, rendered by St. Bernards under the instruction, orders, or directions of such physician(s). I, the undersigned, hereby consent to the taking of photograph(s) for the purpose of identification. Photograph(s) will be part of my medical record. I understand the photograph(s) will be used only for the purpose described. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge and agree that no guarantees have been made to me as to the results or outcome of my medical care.

☐ **I acknowledge the risk of exposure to COVID-19 by receiving treatment at St. Bernards.**

☐ **ASSIGNMENT OF BENEFITS AND OTHER PROCEEDS:** I hereby assign and authorize payment directly to St. Bernards (and to Related Provider(s)) of the following benefits and/or proceeds that are payable to me by any person, entity, or other party: (1) insurance benefits; (2) Medicare, Medicaid, and/or Social Security benefits; (3) injury benefits due because of the liability of a third party; and (4) proceeds of all claims resulting from the liability of a third party. This assignment is valid and binding and will remain so and thus not be withdrawn or voided until final settlement of my charges is received by St. Bernards and/or Related Provider(s). Related Providers include, but are not limited to, Laboratory, Anesthesiology, Radiology, Emergency Services, and Pathology. I certify that the information given by me in applying for payments under Titles XVIII and XIX of the Social Security Act, or under other insurance coverage, is correct. For Title XIX beneficiaries, I understand that I must provide my Medicaid number at the time of admission. I understand that I am fully responsible for St. Bernards's and Related Providers' charges when due. I hold St. Bernards and Related Providers harmless from any reduction in health care benefits by my insurance company resulting from non-compliance with any clause or condition contained in my policy which may require: Notification: Pre-Certification; Prior to Retrospective Authorization, or Utilization Review of the medical service I receive.

☐ **FINANCIAL AGREEMENT**: The undersigned, whether he/she is the patient or is signing as the patient's authorized representative, hereby agrees that the patient and/or Guarantor shall be responsible for any and all services rendered by any and all providers pursuant to these conditions at St. Bernards. The undersigned, whether he/she is the patient or is signing as the patient's authorized representative, hereby further agrees that the patient shall be personally responsible for any and all charges not paid pursuant to the above assignment.

☐ **INFORMATIONAL COMMUNICATIONS**. I am providing St. Bernards with my phone number so that I can receive calls, voicemails and text messages utilizing automatic telephone dialing systems or artificial or pre-recorded voices from St. Bernards and its agents regarding my treatment (such as appointment reminders), services rendered and informational messages regarding my relationship with St. Bernards. I represent that I am permitted to receive communications at the provided number. I agree to promptly alert St. Bernards whenever I stop using the provided number. I understand that my telephone provider may charge me according to the type of plan I carry for any calls or messages received from St. Bernards or its agents. I understand that by providing St. Bernards with an email address at any time, I consent to receive both informational and commercial email messages from St. Bernards and its agents.
Cellular Phone Number:_____

☐ **MARKETING AND BILLING COMMUNICATIONS**: By signing below, I also consent to receive calls, voicemails and text messages at the number listed above from St. Bernards and its agents, including debt collectors, utilizing automatic telephone dialing systems or artificial or pre-recorded voices for marketing, advertising, billing and debt collection purposes. I understand that I am not required to sign below in order to receive treatment or other services from St. Bernards. I further agree that by providing St. Bernards with an email address at any time, I consent to receive email communications for the purposes outlined in this section from St. Bernards and its agents, including debt collectors.
Signature:_____ Initials:_____ Date & Time of Signing:_____

☐ **CONTRABAND**: I understand that any item that may potentially be used to inflict harm on myself or others is considered contraband. Contraband is prohibited. I understand and agree that my person, room or belongings may be searched if St. Bernards has reasonable suspicion that I possess contraband. If illegal contraband is found, St. Bernards may contact the appropriate authorities.

☐ **RETENTION OF TISSUE OR DEVICE:** I understand that if I desire to have tissue or a device transferred or retained by St. Bernards, I must request a copy of the related policy or procedure and comply with the applicable process outlined in such document prior to the removal of such tissue or device.

The above conditions apply to services rendered by St. Bernards and its various departments including the department providing you these conditions but excluding departments that provide you with separate conditions. Assignment of insurance benefits is valid and binding until final settlement of the account is received. The undersigned acknowledges receipt of the HIPAA Privacy Notice and, if applicable, Patient Rights and Responsibilities. The undersigned certifies that he/she has read this form, has received a copy, is the patient or the person authorized to consent on behalf of the patient, and fully understands and accepts these conditions. If the undersigned is signing as the patient's representative, he/she certifies that the patient is not personally able to sign. The undersigned further certifies and warrants that they are authorized by applicable law to sign on behalf of the patient.

_____ Signature of Patient or person authorized to consent _____ If not signed by patient, relationship to patient _____ If not signed by patient, printed name	**The patient receives a copy of this document.** _____ Date & Time of Signing: _____ Signature of St. Bernards Representative

Paragould DOCTORS CLINIC

4000 Linwood Drive, Suite A * Paragould, AR 72450

Permission to Share Information with Family or Friends Involved in Your Care

Patient Name _____ Date of Birth ____/____/____

Social Security # _____

The Health Information Portability and Accountability Act allows providers to disclose medical information to your family members and others involved in your healthcare or payment for their care in certain circumstances. This form allows you to list persons that are involved in your care. By listing a person on this form, you are giving us permission to share your medical information with the person. For example, a listed person may call and receive an update on your condition. However, your medical information will not be shared with a person listed on this form if you are not present and a provider determine that such release of medical information is not in your best interest. You are not required to list any person on this form. If you have any questions concerning this form, please call us at (870) 239-8503. You may revoke this form at any time by providing us written notice of your revocation to 4000 Linwood Drive, Suite A, Paragould, AR 72450.

THE FOLLOWING INDIVIDUALS ARE INVOLVED IN MY CARE:

Name: _____ DOB: _____ Relationship to patient: _____

Name: _____ DOB: _____ Relationship to patient: _____

Name: _____ DOB: _____ Relationship to patient: _____

Name: _____ DOB: _____ Relationship to patient: _____

If any of the persons listed above contact us, they will be asked to identify you by name and date of birth OR social security number (or other reasonable process) and to identify themselves by name and date of birth (or other reasonable process).

I represent that I have fully read and understand this form. I have been given the opportunity to ask questions. All of my questions have been answered.

Note: After the initial completion of this form, any additions or deletions must be given to us in writing.

Signature: _____
Relationship to Patient (if Signed by Personal Representative): _____
Date: _____

****

REVOCATION SECTION

I hereby revoke this authorization: _____ _____
Signature Date

Relationship to Patient (if Signed by Personal Representative): _____

Revocation received by the clinic: _____ _____
Signature Date

Paragould DOCTORS CLINIC

4000 Linwood Drive, Suite A Paragould, AR 72450
Phone: 870-239-8503 Fax: 870-236-1947

Date: _____

Patient ID: _____ Primary ins policy #: _____

Please respond to the following question. PLEASE NOTE: the more honestly you answer, the better equipped our staff will be to assist you:

How often do you have difficulty reading or understanding forms given to you by our staff to sign, understanding medical instructions from our provider or staff, or reading or understanding educational materials given to you by our office staff?

Please circle the answer below:

1- Never 2- Rarely 3- Sometimes 4- Often 5- Always

Thank you!

Paragould Doctors' Clinic

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PATIENT HISTORY (Please Complete ALL Forms)

NAME: DATE:

DRUG ALLERGIES (Type of Reaction)

CURRENT MEDICATIONS (Name, Dose, Frequency)

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Bleeding Disorder						
Diabetes						
Epilepsy/Convulsions						
Glaucoma						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Lung Disease						
Mental Illness						
Stomach/Colon						
Stroke						
Thyroid Disease						
Cancer Type (important):						
Other:						

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PATIENT HISTORY (Please Complete ALL Forms)

NAME:

PAST MEDICAL HISTORY (Circle all that apply)

Recent Weight Loss	Heart Attack	Irritable Bowel Syndrome
Migraine Headaches	High Blood Pressure	Constipation
Epilepsy/Convulsions	High Cholesterol	Other Bowel Problems
Eye Disease (Other than glasses)	Congestive Heart Failure	Liver/Hepatitis
Neurological	Stroke	Kidney/Bladder
Hearing Disorder	Heart Valve Disorder	Anemia
Depression	Angina – Chest Pain	Arthritis
Anxiety	Asthma	Autoimmune Disease
ADHD	COPD	Osteoporosis
Other Mental Illness	Other Lung Disease	Blood Transfusion
Recurrent Nose Bleeds	Diabetes	Stomach Ulcer
Recurrent Sinus/Throat Infections	Alcoholism	Bleeding Disorder
		HIV
OTHERS:	CANCER – Type:	

PAST HOSPITALIZATION OR SURGERIES

REASON:	DATE:

IMMUNIZATIONS

NAME	DATE
Influenza vaccine	
Hepatitis B	
Pneumonia	
Tetanus	

HABITS

Alcohol—Type/Amount:
Any illegal drugs?:

CANCER SCREENING

Colorectal Cancer (e. g. Colonoscopy)
Date:
Normal: Yes No

FOR WOMEN ONLY

Date of last period:	
Do you use birth control: Yes No	
Type of birth control:	
# of pregnancies:	# of live births:
# of miscarriages:	# of abortions:
Date of last PAP:	Normal: Yes No
Mammogram:	Normal: Yes No