MENA MEDICAL ASSOCIATES

A Division of Mena Regional Health System

CONSENT FOR TREATMENT, ASSIGNMENT AND PAYMENT AGREEMENT

I, _____, understand that as part of my healthcare, ***Mena Medical Associates***, originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment and any plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among health professionals, who may contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence for healthcare professionals.

I understand and have been provided with a ***Notice of Privacy Policies*** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice before signing and consent.
- The right to object to the use of my heath information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I understand that ***Mena Medical Associates*** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the code of Federal Regulations.

I further understand that ***Mena Medical Associates*** reserves the right to change their notice and practices before implementation, in accordance with Section 164.520 of the Code of Federal Regulations.

I wish to have the following restriction(s) concerning the use or disclosure of my personal medical information. It is the policy of ***Mena Medical Associates*** not to discuss or give medical information on our patients to anyone. If you wish this information to be released, please indicate your choices below:

Please circle bold choice:

I DO or **DO NOT** hereby give authorization to employees of ***Mena Medical Associates,*** the right to disclose my health information by leaving a message on my answering machine. Phone number (_____) _____.

I DO or **DO NOT** hereby give authorization to employees of ***Mena Medical Associates***, the right to leave health information with my spouse, parent, guardian, or other family member, or friend. Please list the names of the people you wish to have consent to your medical/patient records or information:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship. _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

I acknowledge that I have received the Privacy Notice for Health Information Practices. Initial: _____ Date: _____

IF YOU WOULD LIKE SOMEONE OTHER THAN YOURSELF TO BRING YOUR CHILD TO ***MENA MEDICAL ASSOCIATES,*** AND BE TREATED. PLEASE CIRCLE Y FOR YES OR N FOR NO TO THE RIGHT OF THE RELATION SPACE.

_____ Relation: _____ Able to bring child to MMA: Y / N

_____ Relation: _____ Able to bring child to MMA: Y / N

_____ Relation: _____ Able to bring child to MMA: Y / N

_____ Relation: _____ Able to bring child to MMA: Y / N

I hereby authorize the provider and/or nurse of ***Mena Medical Associates*** to administer such treatment and medication as may be deemed necessary or advisable by the provider in the diagnosis and treatment while I am a patient at this clinic.

I am aware that the practice of medicine is not an exact science and I hereby acknowledge that no guarantees have been made to me as to the results of treatments or examinations at this clinic.

For services rendered to the patient named herein, I promise to pay to the order of the authorized treating provider, on demand. Any monies payable by insurance companies assigned to provider and received by provider will be applied to the balance due. The assignment of insurance monies does not alter the undersigned's obligation to pay.

Provider reserves the right to accept periodic installment payments without waiving its right to demand payment in full. I understand that I am ultimately responsible for this account, regardless of any amount my insurance and/or worker's compensation may pay. I agree to pay all fees and charges made for these services, which may include the cost of collection and/or reasonable attorney fees. I understand and agree that the undersigned, to include patient, patient's spouse, representative, agent, or guarantor, gives consent for ***Mena Medical Associates*** and/or representative to contact them through the use of e-mail and/or cell phones, including voice messages as well as text, land lines, verbally, automatically, and in writing as a means to gather information for medical care, billing, collection and other account issues.

I assign any benefits payable to ***Mena Medical Associates*** for treatment that provides benefits to me. I permit any such assignment of benefits permissible under ARKANSAS STATE OR FEDERAL LAW. If my treatment was caused by events which result in legal action, then I assign ***Mena Medical Associates*** an interest in any claims I may have.

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity and I consent to such discloser for these permitted uses, including disclosure via facsimile. I fully understand and ACCEPT or DECLINE the terms of this consent.

_____ _____

Signature *Date*

If not signed by the patient, please indicate relationship to the patient (e.g Spouse)

_____ _____

Print Name *Relationship*

*THIS FORM EXPIRES EVERY TWELVE MONTHS FROM THE DATE FILLED OUT, UNLESS UPDATED WITH-IN THE TWELVE MONTH TIME FRAME.

Internal Use Only:
If the patient or patient's representative refuses to sign this acknowledgement of receipt of notice, please document the date and time the notice was presented to the patient and sign below.

Presented on (date and time): _____

Presented by (name and title): _____

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PATIENT INFORMATION

Thank you for choosing Mena Medical Associates! In order to serve you properly, we need the following information. All information will be confidential. **PLEASE PRINT.**

TODAY'S DATE: _____

PRIMARY CARE PHYSICIAN: _____ ☐Single ☐Married ☐Widow ☐Divorced

Patient Name: _____ Birth/Maiden Name: _____

Date of Birth: _____ Age: _____ SSN: _____ Race: _____

Ethnicity: _____ Male ___ Female ___ Preferred Language: _____

Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone: _____ Cell Phone _____ E-Mail Address _____

Student? ☐Yes ☐No If yes, ☐Full-Time ☐Part-Time Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____ Work Phone: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____ Phone: _____

RESPONSIBLE PARTY: *Complete this section only if someone other than patient is financially responsible.*

Name _____ Relationship *(Circle)*: Self Parent Grandparent Guardian Other

Address _____ City: _____ State: _____ Zip: _____

SS# _____ Home Phone _____ Date of Birth: _____

Employer _____ Work Phone _____

Employer's Address: _____

Spouse's Name: _____ Spouse's SS#: _____

Spouse's Date of Birth _____ Spouse's Employer: _____

PRIMARY INSURANCE

If you have cards to be copied you do not have to fill out this section

Name of Insurance: _____

Address: _____

_____

Group: _____

Policy ID#: _____

Name of insured on card: _____

SECONDARY INSURANCE

If you have cards to be copied you do not have to fill out this section

Name of Insurance: _____

Address: _____

_____

Group: _____

Policy ID#: _____

Name of insured on card: _____

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay, and non-covered service amounts

Method of Payment for Today's Visit: _____ Cash _____ Check _____ Visa/MC

AUTHORIZATION & RELEASE

I authorize the physician and/or designates to provide medical treatment and release information pertaining to my treatment for insurance purposes. I hereby request that payment under the medical insurance program be made either to me or to the physician for charges therein. I certify that the above information is correct and I understand that I am responsible for all bills regardless of insurance coverage of any kind. By signing this, I am giving permission to contact me by either cell phone or email with medical or financial information that pertains to this office. A photocopy of the assignment is to be considered as valid as the original.

_____ _____

Signature of Responsible Party *Date*

MENA MEDICAL ASSOCIATES
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HISTORY SHEET

NAME: _____ AGE: _____ DATE: _____

REASON FOR VISIT: _____

ARE YOU ALLERGIC TO ANY FOOD OR MEDICATIONS? YES ___ NO ___ IF YES, PLEASE LIST: _____

_____

LATEX ALLERGY? _____ SEAFOOD OR IODINE? _____ TYPE OF REACTION: _____

PHARMACY: _____ REFERRING PHYSICIAN: _____

MEDICATION LIST (SEE SHEET DATED: _____) Weight: _____ Height: _____

Please list past surgical history on back.

Have YOU or your FAMILY ever had any of the following? (Check all that apply)

	Self	Father	Mother	Maternal Grandmother (Mother's Mother)	Maternal Grandfather (Mother's Father)	Paternal Grandmother (Father's Mother)	Paternal Grandfather (Father's Father)	Son	Daughter	Brother	Sister	Does not apply
Kidney Disease												
Lung Disease												
High Blood Pressure												
Diabetes												
Asthma												
Arthritis												
Cancer												
Heart Disease												
Ulcers												
Hepatitis												
Stroke												
Tuberculosis												
Blood Clots												
Bronchitis												
Seizures												
Anxiety / Depression												
Muscular Disease												
Bleeding Tendencies												
Fever or Muscle weakness related to anesthesia												

Have you seen a Gastroenterologist in the past 5 years? YES ____ NO ____

Childhood illnesses: Measles ___ Mumps ___ Rubella ___ Whooping Cough ___ Chicken pox ___
Rheumatic Fever ___ Scarlet Fever ___ Polio ___

List exposure to the following: Tuberculosis ___ HIV ___ Chicken Pox ___ Herpes Zoster (Shingles) ___

Gastrointestinal: Peptic Ulcer dz ___ Inflammatory bowel dz ___ Diverticulitis ___ Chron's ___ Ulcerative Colitis ___ Celiac sprue ___ Irritable bowel syndrome ___ Diarrhea ___ Constipation ___ Bloody stools ___ Bright red bloody stools ___ Dark bloody stools ___ Hemorrhoids ___ Frequent rectal bleeding ___ Abdominal pain ___ Heartburn / indigestion ___ Belching ___ Food intolerance ___ Food Allergies ___ Exposure to hepatitis A,B,C ___ Jaundice ___ Excessive alcohol use ___ Gallbladder pain ___ Pancreatitis ___ Colon cancer ___ Hospitalization from constipation or impactions ___ Pancreatitis, GI bleeding ___ Explain:

_____

_____

Past Medical Illness: List conditions which required hospitalization or medications routinely. Include accidents and psychiatric illnesses.

YEAR	ILLNESS	YEAR	ILLNESS

Past Surgical History: Including cataracts, EGD's, colonoscopy, skin excisions, cryotherapy. List dates of surgeries and findings.

YEAR	OPERATION	DOCTOR/S NAME	FINDINGS

Have you had any problems from past surgery? If so, what are the problems?

Neck or Back Pain/Problem Yes _____ No _____

Any Religious Restrictions Yes _____ No _____

Date of last Menstrual Period: _____

Are you Pregnant? Yes____ No____

Do you use Tobacco? Yes___ No ___ Not any more _____ Started / Since _____ Year Quit _____ How Much _____

Do you use Alcohol? Yes ___ No ___ Socially _____ Daily _____ Started / Since _____ Year Quit _____ How much _____

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FORMULARY BENEFITS DATA CONSENT

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PMB's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By Signing below I give permission for Mena Medical Associates to access my pharmacy benefits data electronically through RxHub. This consent will enable Mena Medical Associates to:

- Determine the pharmacy benefits and drug co-pays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by an provider.

In summary, we ask permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

Patient Name (Printed) _____ Date of Birth _____

Patient / Guardian Signature _____ Date _____

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MEDICATION LIST

NAME: _____ DOB: _____ PATIENT # _____

ALLERGIES - DRUG REACTIONS

Phone: _____

Pharmacy: _____

Phone: _____

MEDICATIONS / STRENGTH HERBS / VITAMINS	DIRECTIONS	OTC

MEDICATIONS / STRENGTH HERBS / VITAMINS	DIRECTIONS	OTC

MENA MEDICAL ASSOCIATES

A Division of Mena Regional Health System

1103 COLLEGE DRIVE

MENA, AR 71953

Phone 479-394-1414 Fax 479-437-3786 or 877-775-6761

PAIN MANAGEMENT ACKNOWLEDGEMENT

NEW PRESCRIPTIONS: Will not be issued without first seeing your physician/provider in most circumstances.

PRESCRIPTION REFILLS: Contact your pharmacy to request a refill on all medications that do not require a written prescription. If you request your prescription from our office, please give us **48 hours** advance notice.

CONTROLLED SUBSTANCES / NARCOTICS / BENZODIAZEPINES: Our clinic **does not** provide pain management services. In some circumstances we may prescribe a controlled substance/narcotic to a patient. We require you to provide us with names of any other medical providers or dentists that you may have seen in the past year that has prescribed you this type of medication. We also require you disclose the name of the pharmacy you will use and have used. You, as part of your treatment, will be required to refrain from receiving this type of medication from any other providers during your course of treatment with us. Like any chronic medication, we will monitor with random pill counts and urine drug screens. **If we obtain information that you have filled or received a prescription from another provider during your treatment with us, we will contact the prosecuting attorney's office or local law enforcement and provide them with this information.** By signing this policy, you give us the right to report this information. If you break this policy or do not disclose **all** information, we will terminate our physician/patient relationship.

PLEASE LIST ALL PROVIDERS, MEDICATION AND DATES BELOW:

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Printed Patient Name *Date of Birth*

_____ _____

Patient Signature *Date*

MMA 017 05/2017

MENA REGIONAL HEALTH SYSTEM

Specializing in You!

Mena Regional Health System
Privacy Notice for Health Information Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- a tool in educating heath professionals
- a source of data for medical research
- a source of information for public health officials charged with improving the health of the nation
- a source of data for facility planning and marketing
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve
- Understanding what is in your record and how your health information is used helps you to:
  - ✓ ensure its accuracy
  - ✓ better understand who, what, when, where, and why others may access your health information
  - ✓ make more informed decisions when authorizing disclosure to others

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

Patient Rights with Respect to PHI

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

- **Right to Request Restrictions:** You have the right to request that we restrict use or disclosure of your PHI for treatment, payment, or health care operations. However, we are not required to agree in all circumstances to the patient's requested restriction. If you ask Mena Regional Health System not to share your information with your health plan we will not disclose your PHI to the health plan if you pay the full cost for your care in advance.
- **Right to Request Confidential Communication:** You have the right to request PHI in a certain form or at a specific location. Your request must be in writing. For instance, you can request that we not contact you at work, and you can tell us how and/or where you want to receive information. We will accommodate reasonable requests. If your request for confidential communication is approved, we will honor your request until you tell us in writing that you revoke the request for the confidential communication. I understand that the phone number given to Mena Regional Health System will be considered my contact number.

- **Right to Inspect and Copy Your Protected Health Information:** You have the right to review and/or ask for a copy of your PHI, including medical records, billing records and other records. Your request must be in writing. If you request copies of information, we may charge a fee for costs associated with your request, including the cost of copies, postage or other supplies. You also have the right to an electronic copy of your information.

  In rare circumstances we may deny access to your protected health information. If access is denied, you can request that the denial be reviewed. A licensed health care professional chosen by Mena Regional Health System will review your request and make a final decision as to whether the information should be released.
- **Right to Request Amendment to Your Protected Health Information (PHI):** You have a right to request that your PHI be amended (changed) if you believe that it is incorrect or incomplete. Your request must be in writing. You must obtain the request form from the Health Information Management Office or your provider, submit the completed form and provide the reason that you want the amendment.

  Mena Regional Health System can deny your request if: (1) it is not in writing or it does not include a reason why the information should be changed, (2) the information you want to change was not created by Mena Regional Health System; (3) the information is not part of the medical record kept by Mena Regional Health System; (4) the information is not part of the information that you are permitted to inspect or copy; or (5) the information contained in the record is accurate and complete.
- **Right to an Accounting of Disclosures:** You have the right to receive an accounting of disclosures of medical information that we have made, with some exceptions. Your request must be in writing and must state the time period for the requested information. Mena Regional Health System will not provide this information for a time period greater than six (6) years from the date of your request. You have the right to receive one (1) free accounting every twelve (12) months. If you request more than one (1) accounting in any twelve (12) month period, we may charge you a reasonable fee for the costs of providing that list.
- **Right to Receive a Copy of the Notice of Privacy Practices:** You have the right to a paper copy of this Notice and may print a copy from menaregional.com website. If you want a paper copy of this Notice mailed to you or to exercise any of your rights outlined above, please send a written request to the Director of Health Information Management.

Examples of Disclosures for Treatment, Payment and Health Operations (TPO)
We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health care operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, and certain laboratory tests. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your

information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you wish that your information not be used for such purposes, please contact the Director of Marketing at 479-243-2378.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers' compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the Mena Regional Health System Privacy Officer at 479-243-2356.

If you believe your privacy rights have been violated, you can file a complaint with the Mena Regional Health System Privacy Officer or with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

In the event your complaint remains unsolved with Mena Regional Health System or Mena Medical Associates, you may file a complaint with our Accreditor, The Compliance Team, via their website (www.thecomplianceteam.org) or via phone 1-800-291-5353.

Effective Date: November 1st, 2002

Revised: September, 4, 2019