Carriage Hill Family Care, PLC
3501 Carriage Hill Dr Ste B | Paragould, AR 72450 | P: (870) 573-2200 | F: (870) 573-2300

NEW PATIENT REGISTRATION & HEALTH HISTORY

Please complete all applicable sections before your first visit. Bring your photo ID, insurance card(s), and a current medication list or bottles.

OUR PROVIDERS

Vincent Lee, MD | Cecil Massey, APRN | Teresa Gonzalez, APRN | Latoya Coward, APRN
Lauren Willmer, APRN | Allyssa Beall, APRN | Diane Underwood, APRN | Laura Needham-Puckett, EdS, LPC-S, RPT-S

Thank you for choosing CHFC. We care for patients of all ages. At your first visit, staff will review your history, medications and allergies; record information in our secure electronic medical record; measure routine vital signs such as height, weight, temperature and blood pressure; and ask questions related to your concerns. Depending on the visit, you may be asked to change into a gown. Your provider will discuss your assessment, treatment plan and follow-up. Questions or feedback: (870) 573-2200 | www.CHFamilyCare.com

PATIENT INFORMATION

Date: _____ Account # (Office Use): _____

First name: _____ Middle name: _____ Last name: _____

Date of birth: _____ Sex: _____ SSN: _____

Mailing address: _____

City: _____ State: _____ ZIP: _____

Physical address: _____

City: _____ State: _____ ZIP: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Email: _____ Preferred language: _____

Local pharmacy: _____ Pharmacy city/town: _____

Occupation: _____ Level of education: _____

Preferred pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other: _____ ☐ Prefer not to answer
Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered ☐ Other: _____
Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Multiracial ☐ Other: _____
Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Prefer not to answer
Tobacco/smoking: ☐ No ☐ Yes If yes, packs per day: _____ Number of years: _____

RESPONSIBLE PARTY / PARENT / GUARDIAN (IF APPLICABLE)

First name: _____ Middle name: _____ Last name: _____
Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other: _____

Date of birth: _____ Sex: _____

Address: _____
City: _____ State: _____ ZIP: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Email: _____ SSN: _____

OPTIONAL: PEOPLE CHFC MAY DISCUSS MY CARE WITH

Complete this optional section if you want CHFC to document people who may be involved in your care or payment.

Emergency contact: _____
Phone: _____ Relationship: _____

ADDITIONAL PEOPLE CHFC MAY DISCUSS MY CARE WITH

Name	Relationship	Phone

Information CHFC may discuss: ☐ Information relevant to my care/payment ☐ Only: _____
Restrictions: ☐ Mental/behavioral health ☐ HIV/communicable disease ☐ Alcohol/drug/SUD treatment ☐ Other: _____
For release of a complete medical-record copy, use the Authorization to Release Health Information.
Patient initials authorizing the emergency contact and any additional people listed above: _____ Duration: ☐ Until revoked ☐ Until: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance plan / company: _____

Insured first name: _____ Middle name: _____

Insured last name: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____ Insured DOB: _____

Member / ID #: _____

Group #: _____

Insurance address: _____

City: _____ State: _____ ZIP: _____

SECONDARY INSURANCE (IF APPLICABLE)

Insurance plan / company: _____

Insured first name: _____ Middle name: _____

Insured last name: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____ Insured DOB: _____

Member / ID #: _____

Group #: _____

Insurance address: _____

City: _____ State: _____ ZIP: _____

Please present all current insurance cards. If you have additional coverage, tell the receptionist so it can be added to your account.

HEALTH HISTORY

Complete as accurately as possible. If you are unsure, leave the item blank and discuss it with your care team.

ALLERGIES

Drug / medication allergies - include the type of reaction. If none, write "None."

Medication / substance	Reaction

CURRENT MEDICATIONS

Include medication name, dose/strength, and how often you take it. You may attach a current medication list instead.

Medication	Dose / strength	How often

FAMILY HISTORY

Check the relative(s) affected. For cancer, write the cancer type if known.

Condition	Father	Mother	Father's parents	Mother's parents	Siblings	Children
Bleeding disorder	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/convulsions	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐

Condition	Father	Mother	Father's parents	Mother's parents	Siblings	Children
Lung disease	☐	☐	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐	☐	☐
Stomach/colon	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐
Cancer - type:	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐

PAST MEDICAL HISTORY - CHECK ALL THAT APPLY

☐ Recent weight loss	☐ Migraine headaches	☐ Epilepsy/convulsions
☐ Eye disease (other than glasses)	☐ Neurological disorder	☐ Hearing disorder
☐ Depression	☐ Anxiety	☐ ADHD
☐ Other mental illness	☐ Recurrent nose bleeds	☐ Recurrent sinus/throat infections
☐ Heart attack	☐ High blood pressure	☐ High cholesterol
☐ Congestive heart failure	☐ Stroke	☐ Heart valve disorder
☐ Angina/chest pain	☐ Asthma	☐ COPD
☐ Other lung disease	☐ Diabetes	☐ Alcohol use disorder
☐ Cancer - type: _____	☐ Irritable bowel syndrome	☐ Constipation
☐ Other bowel problems	☐ Liver disease/hepatitis	☐ Kidney/bladder disease
☐ Anemia	☐ Arthritis	☐ Autoimmune disease
☐ Osteoporosis	☐ Blood transfusion	☐ Stomach ulcer
☐ Bleeding disorder	☐ HIV	☐ Other: _____

PAST HOSPITALIZATIONS / SURGERIES

Reason / procedure	Date

PREVENTIVE HISTORY / HABITS

IMMUNIZATIONS	HABITS	CANCER SCREENING
Influenza vaccine: _____	Alcohol type/amount: _____	Colorectal screening (e.g., colonoscopy):
Hepatitis B: _____	Any illegal/recreational drugs? _____	Date: _____ Normal: ☐ Yes ☐ No
Pneumococcal: _____	Other: _____	
Tetanus/Tdap: _____		

FOR WOMEN ONLY (IF APPLICABLE)

Date of last menstrual period: _____	Birth control: ☐ No ☐ Yes Type: _____
# pregnancies: _____ # live births: _____	# miscarriages: _____ # abortions: _____
Date of last PAP: _____	Normal: ☐ Yes ☐ No
Mammogram date: _____	Normal: ☐ Yes ☐ No

CONSENT, INSURANCE, FINANCIAL & COMMUNICATION TERMS

CONSENT FOR CARE

I voluntarily consent to receive medical and healthcare services from Carriage Hill Family Care, PLC ("CHFC"). I understand this may include services by my provider, provider assistants and designees, including medical students, residents or fellows, and CHFC employees as deemed necessary or advisable in their judgment. I understand CHFC may use telehealth services and, when appropriate and permitted by law, photographs, camera surveillance and/or video recordings for treatment, payment, or healthcare operations. I authorize the disposal of tissues removed in the course of an authorized procedure unless other arrangements are made. I understand that the practice of medicine and surgery is not an exact science, that treatment involves consideration of risks and benefits, and that no guarantees have been made regarding the result of my examination or treatment.

ASSIGNMENT OF INSURANCE BENEFITS

I assign to CHFC all rights and benefits to which I may be entitled arising out of any healthcare or liability insurance policy, Medicare, or Medicaid, and authorize payment of benefits directly to CHFC when permitted. I authorize CHFC to pursue full and undiscounted payment on my account from any available liability insurance policy or other responsible third-party source before, or in coordination with, submission of my account to my health insurance plan, Medicare, or Medicaid. I agree to hold CHFC harmless for reductions in healthcare benefits caused by my noncompliance with any clause or condition in my insurance policy requiring notification, precertification, prior or retrospective authorization, or utilization review of the medical services I receive. This assignment of insurance benefits is valid and binding until final payment of the account is received.

FINANCIAL RESPONSIBILITY AND PAYMENT REQUEST

The undersigned, jointly and severally, in consideration for services rendered to the patient, accepts financial responsibility and agrees to pay all applicable deductibles, copayments, coinsurance, noncovered services, and any estimated self-pay amounts at or before the time services are rendered. The undersigned agrees to promptly pay any remaining balance after insurance adjudication in accordance with CHFC billing statements and payment terms. If an indebtedness is placed in the hands of a collector or attorney for collection, the undersigned agrees to pay reasonable attorney fees, interest, court costs, and other collection costs and expenses to the extent permitted by law. I understand that I may qualify for financial assistance and may request a determination. I understand that eligibility may depend on timely submission of appropriate financial documentation and that failure to provide requested documentation may affect qualification. I request payment of authorized benefits on my behalf. I assign payment for unpaid charges for certain physicians' or specialists' services for whom CHFC is authorized to bill. I understand that I remain responsible for health insurance deductibles, coinsurance, and other amounts not covered by insurance. I certify that information I provide in applying for payment under Titles XVIII and XIX of the Social Security Act is correct.

COMMUNICATIONS REGARDING MY ACCOUNT

I agree that CHFC, any collection or servicing agency, or agencies retained by CHFC to collect money I owe may contact me by telephone or text message at any number associated with my demographic information, including cellular or wireless numbers, which may result in fees from my carrier. To the extent permitted by law, I understand and agree that these contacts may use automatic dialing devices, prerecorded messages, artificial-voice messages, or voicemail messages.

COMMUNICATIONS REGARDING MY CARE

I agree that CHFC may contact me by telephone or text message at any number associated with my demographic information for care coordination, quality-improvement activities, appointment reminders, and wellness campaign reminders. This may include cellular or wireless numbers and may result in fees from my carrier. To the extent permitted by law, I understand and agree that these contacts may use automatic dialing devices, prerecorded messages, artificial-voice messages, or voicemail messages.

USE AND DISCLOSURE OF HEALTH INFORMATION

I understand that CHFC will generate, receive, and store protected health information regarding my diagnosis and treatment. This information may include mental-health information, information regarding drug or alcohol use, communicable-disease information such as HIV/AIDS, and other sensitive information. I understand that the Notice of Privacy Practices explains how CHFC and its workforce may use and disclose my information for treatment, payment, healthcare operations, and other purposes permitted or required by law. For payment, benefits administration, and matters related to treatment or charges, CHFC may disclose information as permitted by law to persons, corporations, or agencies that may be liable for all or part of CHFC's charges or responsible for determining the necessity, appropriateness, amount, or other matter related to treatment or charges, including insurance companies, health maintenance organizations, preferred provider organizations, liability insurers, workers' compensation carriers, welfare funds, and the Social Security Administration or its intermediaries or carriers. CHFC may also disclose information to its insurance carrier when requested and permitted by law and to an employer when the employer is legally responsible for the charges. This consent and acknowledgment does not replace a separate HIPAA authorization when one is required by law.

DOCUMENT REVIEW AND LITIGATION SERVICES

The undersigned, jointly and severally, irrevocably agree to pay for all work performed by Carriage Hill Family Care, PLC, in any way related to litigation or potential litigation on the following terms and conditions.

SERVICE	LPC	APRN / MD
Retainers (Prepaid, Credited Toward Services)	6-hour minimum retainer at $250/hour = $1,500, non-refundable once work begins	6-hour minimum retainer at $350/hour = $2,100, non-refundable once work begins
Case Review (Billed in 1-Hour Increments)	$250/hour Initial Case Review Telephone Consultation Face-to-Face Consultation Report Writing	$350/hour Initial Case Review Telephone Consultation Face-to-Face Consultation Report Writing
Depositions	4-hour minimum prepaid: $1,000 Additional time: $250/hour (billed on day of service)	4-hour minimum prepaid: $1,400 Additional time: $350/hour (billed on day of service)

All Providers:
• 50% of the deposit due at scheduling; balance due 4 weeks before date
• Cancellation Policy: 3+ weeks: full refund; 2 weeks: 50% refund; <1 week: no refund
• Preparation time billed at consultation rate

Trial Testimony (Minimum 8-Hour Reserved Block)
LPC: $250/hour -> $2,000 minimum per 8-hour block | APRN/MD: $350/hour -> $2,800 minimum per 8-hour block
• All trial time is billed in full-day (8-hour) blocks regardless of actual duration
• Time includes portal-to-portal travel, waiting, and testimony
• First day prepaid in full; subsequent days billed in half-day increments (1 PM = half-day mark)
• One-day retainer due 4 weeks prior to scheduled testimony/travel date

Premiums and Rush Fees
• After-Hours Premium: Time exceeding the reserved window or scheduled outside of standard business hours (M-F, 8 AM-5 PM) may be billed at 1.5x the hourly rate
• Rush Fee: Requests for appearances or reports with less than 2 weeks' notice may incur a 20% rush fee

Other Terms
• All records must be submitted electronically
• Reimbursement at actual cost for travel, lodging, and other out-of-pocket service-related expenses (e.g., printing, certifying)
• Balances unpaid after 30 days are subject to a 5% monthly late fee

PATIENT ACKNOWLEDGMENT AND SIGNATURE

By signing below, I certify that I have read or have had read to me the Consent, Insurance, Financial & Communication Terms and the Document Review and Litigation terms in this packet. I understand and accept these terms and acknowledge that I have received or was offered a copy.

Patient / guardian signature: _____	**Date: _____**
Printed name: _____	Relationship / authority if not patient: _____
If patient is unable to consent or is a minor, reason: _____	
Insured / policyholder signature (only if different from patient and required by payer): _____	Date: _____

NOTICE OF PRIVACY PRACTICES

Effective Date: August 21, 2026 | Privacy Contact: Privacy Officer | Phone: (870) 573-2200

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO IT. PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS

Get an electronic or paper copy of your medical record: You may ask to see or receive an electronic or paper copy of your medical record and other health information we maintain about you. We generally provide a copy or summary within the time required by law and may charge a reasonable cost-based fee.

Ask us to correct your record: You may ask us to correct health information you believe is incorrect or incomplete. If we deny your request, we will explain why in writing within the time required by law.

Request confidential communications: You may ask us to contact you in a particular way, such as at a home or office phone, or at a different mailing address. We will accommodate reasonable requests.

Ask us to limit what we use or share: You may ask us not to use or disclose certain information for treatment, payment, or health care operations. We are not always required to agree. If you pay for a service or health care item in full out of pocket, you may ask us not to disclose that information to your health plan for payment or health care operations, and we will agree unless law requires disclosure.

Get an accounting of certain disclosures: You may ask for a list of certain disclosures made during the six years before your request. The accounting does not include every disclosure, such as many disclosures for treatment, payment, or health care operations. You may receive one accounting without charge in a 12-month period; we may charge a reasonable cost-based fee for additional requests.

Get a copy of this notice: You may request a paper copy of this notice at any time, even if you agreed to receive it electronically.

Choose someone to act for you: If you have given someone medical power of attorney, have a legal guardian, or otherwise have a legally authorized personal representative, that person may exercise your privacy rights. We will verify the person's authority before acting.

File a complaint: You may complain to CHFC if you believe your privacy rights were violated. You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. CHFC will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain uses and disclosures, you may tell us your preference. When you have a clear preference, tell us what you want us to do.

- You may tell us whether to share information with family, close friends, or others involved in your care or payment for your care.
- You may tell us whether to share information in a disaster-relief situation.
- If you cannot tell us your preference, we may share information when we believe it is in your best interest or when needed to prevent a serious and imminent threat to health or safety.
- We will obtain your written authorization for marketing, sale of your health information, and most uses or disclosures of psychotherapy notes when authorization is required by law.

HOW WE TYPICALLY USE OR SHARE YOUR INFORMATION

Treatment: We may use your health information and share it with other health professionals who are treating you.

Health care operations: We may use and share your health information to run our practice, improve care, coordinate services, conduct quality activities, and contact you when necessary.

Payment: We may use and share your health information to bill and obtain payment from health plans or other responsible entities.

Business associates: We may share information with vendors and business associates that perform services for us. They are required to safeguard the information as required by law.

NOTICE OF PRIVACY PRACTICES - CONTINUED

OTHER USES AND DISCLOSURES PERMITTED OR REQUIRED BY LAW

We may use or share health information when applicable legal requirements are met, including for:

- Public health and safety activities, including disease reporting, product recalls, adverse-event reporting, and preventing or reducing serious threats to health or safety.
- Reporting suspected abuse, neglect, or domestic violence when authorized or required by law.
- Health oversight activities and certain government functions.
- Research when legal requirements are satisfied.
- Comply with the law. We will use or disclose your health information when state or federal law requires it, including to the U.S. Department of Health and Human Services when it reviews our compliance with federal privacy law.
- Organ and tissue donation.
- Coroners, medical examiners, and funeral directors.
- Workers' compensation claims.
- Law enforcement or other government requests when permitted or required by law.
- Court orders, subpoenas, lawsuits, and other legal proceedings when permitted or required by law.

SPECIAL PROTECTIONS FOR CERTAIN RECORDS

Substance use disorder records: To the extent CHFC creates, maintains, or receives records protected by 42 CFR Part 2, those records have additional federal confidentiality protections. Part 2-protected records generally may not be used or disclosed in civil, criminal, administrative, or legislative investigations or proceedings against you without your specific written consent or a qualifying court order and legal process. Separately maintained SUD counseling notes require specific consent when applicable.

Psychotherapy notes: Psychotherapy notes that meet the HIPAA definition and are maintained separately from the medical record receive special protection. Most uses or disclosures require a separate authorization.

Other specially protected information: Arkansas and federal laws provide additional confidentiality protections for certain health information. Depending on the record and the circumstances, additional restrictions or specific written authorization may apply to mental-health information, HIV/AIDS and certain communicable-disease information, family-planning and reproductive-health information, substance-use treatment information, sexually transmitted disease information, genetic information, and other specially protected records. When applicable law requires written authorization or imposes additional limits on disclosure, CHFC will obtain the required authorization and follow those restrictions unless disclosure is otherwise permitted or required by law.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will notify you as required by law if a breach occurs that may compromise the privacy or security of your information.
- We must follow the duties and privacy practices described in the notice currently in effect.
- We will not use or share your information other than as described in this notice unless you authorize us in writing or the law otherwise permits or requires it.

CHANGES TO THIS NOTICE / QUESTIONS OR COMPLAINTS

We may change the terms of this notice, and the changes may apply to information we already have about you. The revised notice will be available upon request, in our office, and on our website.

Questions or privacy complaints may be directed to CHFC at (870) 573-2200, 3501 Carriage Hill Dr Ste B, Paragould, AR 72450. You may also contact the U.S. Department of Health and Human Services, Office for Civil Rights. CHFC will not retaliate against you for filing a complaint.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received Carriage Hill Family Care, PLC's Notice of Privacy Practices. My signature acknowledges receipt of the Notice; it does not authorize uses or disclosures of my health information beyond those permitted by law. If I decline or am unable to sign, CHFC may document its good-faith effort to obtain this acknowledgment.

Patient / guardian signature: _____	**Date: _____**
Printed name: _____	Relationship if not patient: _____

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

REQUEST RECORDS TO CHFC - COMPLETE ALL SECTIONS, DATE, AND SIGN

I. PATIENT AUTHORIZATION

I, _____, authorize the disclosure of information from my medical record.

Birthdate: _____ SSN (last 4 digits): XXX-XX-_____

Phone: _____ Address, City, State, Zip: _____

Email: _____

II. RELEASING AND RECEIVING INFORMATION

THE INFORMATION IS TO BE DISCLOSED BY:

Name of facility / person: _____

Address, City, State, ZIP: _____

Phone: _____ Fax: _____

THE INFORMATION IS TO BE PROVIDED / SENT TO:

Carriage Hill Family Care, PLC
3501 Carriage Hill Dr Ste B, Paragould, AR 72450
Phone: (870) 573-2200 Fax: (870) 573-2300

III. PURPOSE OR NEED FOR THIS DISCLOSURE

☐ Continued treatment ☐ Personal use ☐ Attorney ☐ Insurance ☐ School ☐ Disability ☐ Research ☐ Other: _____

IV. INFORMATION TO BE DISCLOSED FROM MY MEDICAL RECORD (CHECK APPROPRIATE BOX/ES)

☐ Only information related to (specify): _____

☐ Only for dates of service from _____ to _____

☐ Other (specify; e.g., radiology, laboratory, billing): _____

☐ Entire record

V. IF YOU WOULD LIKE ANY OF THE FOLLOWING SENSITIVE INFORMATION DISCLOSED, CHECK THE APPLICABLE BOX/ES BELOW

☐ Substance Use Disorder (SUD) Diagnosis/Treatment/Referral
☐ Mental Health (Other than Psychotherapy Notes)
☐ Sexually Transmitted Diseases
☐ Genetic Testing
☐ HIV/AIDS Testing & Treatment
☐ Sexual & Reproductive Health

Psychotherapy notes and separately maintained SUD counseling notes require a separate authorization/consent when applicable.

Preferred delivery (optional): ☐ Fax ☐ CD ☐ Mail/paper ☐ Secure electronic ☐ Other: _____

VI. VOLUNTARY AUTHORIZATION / NON-CONDITIONING

I understand that by signing this authorization, my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

VII. REDISCLOSURE

I understand that information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA. Other federal or state confidentiality protections may continue to apply.

VIII. REVOCATION

I may revoke this authorization by notifying the facility/person identified above as releasing the information in writing of my desire to revoke it. However, I understand that actions already taken based on this authorization cannot be reversed and my revocation will not affect those actions.

IX. EXPIRATION

This authorization expires on _____, 20____, OR upon the following event: _____

If no date or event is specified, this authorization will automatically expire one (1) year from the signature date.

SIGNATURE OF PATIENT: _____ **DATE: _____**

SIGNATURE OF PERSONAL REPRESENTATIVE & RELATIONSHIP/AUTHORITY TO ACT FOR PATIENT:

_____ DATE: _____

SIGNATURE OF WITNESS (if signature of patient is a thumbprint or mark):

_____ DATE: _____

A photocopy, faxed copy, or electronic copy of this signed authorization may be relied upon as if it were the original.