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

Welcome to Carriage Hill Family Care, PLC

What to Expect During Your First Visit

Thank you for choosing Carriage Hill Family Care, PLC for your health care needs. During your first visit, you will meet our staff, complete a few brief forms and, of course, meet your medical provider. As family health providers, we serve patients of all ages from newborns to great grandparents. We will try to solve your current medical problem and detect or prevent other health problems. We hope to make the first visit not just an opportunity to deal with any medical concerns you may have but also a time to get acquainted with you.

The First Examination

When you enter the exam room, you will be asked to fill out a health questionnaire by a staff member. We will measure your height and weight, take your temperature, and check your blood pressure. We will review the health questionnaire, review your medications, allergies and ask you additional questions pertinent to your issues. We will also record the data into our secure electronic medical records. Thank you for your patience. Depending on your problem, you may be asked to undress and put on a gown in the privacy of the exam room. This enables us to better evaluate your health. After the examination, your medical provider will suggest a treatment plan and future visits, if necessary.

We hope that after your visit you will feel confident that you have made a wise decision by choosing our practice. If you have any feedback, please ask our front staff to provide you with a feedback card or go to our website at www.CHFamilyCare.com to send us an email.

Thank you for allowing us to participate in your health care,

Carriage Hill Family Care, PLC

Our Providers

Dr. 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

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

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: _____

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

Email: _____

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

Local Pharmacy: _____ Town: _____

Preferred Language: _____ Level of Education: _____

Marital Status: Married Single Widowed Occupation: _____

Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other: _____

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: _____

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

Email: _____

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

Insurance Information

Primary Insurance: _____

Name of Insured: (Last) _____ **(First)** _____ **(Middle)** _____

Insured Party: Self Spouse Parent Other **Insured's Date of Birth:** _____

ID #:_____ **Group #:**_____

Insurance Address: _____

City: _____ **State:** _____ **ZIP:** _____

Secondary Insurance: _____

Name of Insured: (Last) _____ **(First)** _____ **(Middle)** _____

Insured Party: Self Spouse Parent Other **Insured's Date of Birth:** _____

ID #:_____ **Group #:**_____

Insurance Address: _____

City: _____ **State:** _____ **ZIP:** _____

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

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

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

HIPAA Authorization Form for Family Members/Friends

I, _____(Print), give permission to all my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name(s):	*Relationship:*
_____	_____
_____	_____
_____	_____

Health Information to be disclosed (Check all that apply):

- ☐ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR
- ☐ My complete health record, as above, with the exception of the following information:

(check as appropriate):

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify_____
  _____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:_____
  unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

X _____
Name of the Individual Giving this Authorization

X _____ _____
Signature of the Individual Giving this Authorization Date

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

PATIENT HISTORY (Please Complete ALL Forms)

NAME: **DATE:**

DRUG ALLERGIES (Include Type of Reaction)

CURRENT MEDICATIONS (Include 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:						

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

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

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

CONSENT: I voluntarily consent to receive medical and healthcare services from Carriage Hill Family Care, PLC (referred to hereafter as "provider". I understand this may include services by my provider, provider's assistants and designees, including medical students, residents or fellows, and employees of provider as is deemed necessary or advisable in their judgment. I authorize the use of telehealth services, photographs, camera surveillance and/or video recordings as needed for the purpose of treatment, payment, or healthcare operations. I authorize the disposal of any tissues removed in the course of any authorized procedure. I am aware that the practice of medicine and surgery is not an exact science; that it involves my informed acceptance of certain risks versus benefits, and I acknowledge that no guarantees have been made to me as a result of my examination and/or treatments.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all rights and benefits to which I may be entitled arising out of any healthcare or liability insurance policy, Medicare or Medicaid to provider. I authorize the full and undiscounted pursuit of payment on my account from any available liability insurance policy or third party source before submission of my account for payment to my own health insurance company or to Medicare or Medicaid. I hold provider harmless of any reduction in healthcare benefits by my insurance company resulting from noncompliance with any clause or condition contained in my policy which may require: Notification; Precertification; Prior to Retrospective Authorization; or Utilization Review of the medical services I receive. 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 the services rendered to the above-named patient, accepts financial responsibility and agrees to pay all applicable deductibles, copayments, coinsurance, and any estimated self-pay amounts at or before the time services are rendered. The undersigned also agrees to promptly pay any remaining balance after insurance adjudication, in accordance with the provider's billing statement and payment terms. The undersigned further agrees that if such indebtedness is placed in the hands of a collector or an attorney for collection, the undersigned will pay reasonable attorney fees, interest, court costs and other collection costs and expenses. I also understand that I may qualify for financial assistance programs and that I may secure a determination of such upon request. I further understand that such a determination is dependent upon my timely submittal of appropriate financial documentation and my failure to provide any such documentation could affect my qualification for financial assistance. I request that payment of authorized benefits be made on my behalf. I assign payment for unpaid charges for certain physicians' services furnished by specialists, and physicians for whom provider is authorized to bill. I understand that I am responsible for any health insurance deductibles and coinsurance. I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I agree that I am financially responsible for deductibles and co-insurance not covered by my insurance.

DOCUMENT REVIEW AND LITIGATION: 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.

Retainers (Prepaid, Credited Toward Services)

- **LPC**: 6-hour minimum retainer at $250/hour = **$1,500**, non-refundable once work begins
- **APRN/MD**: 6-hour minimum retainer at $350/hour = **$2,100**, non-refundable once work begins

Case Review (Billed in 1-Hour Increments)
LPC: $250/hour
APRN/MD: $350/hour

- Initial Case Review
- Telephone Consultation
- Face-to-Face Consultation
- Report Writing

Depositions
LPC:
- 4-hour minimum prepaid: **$1,000**
- Additional time: $250/hour (billed on day of service)

APRN/MD:
- 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**

CONTACT BY PHONE:

COMMUNICATIONS REGARDING MY ACCOUNT:
I agree that provider, any other collection or servicing agency, or agencies retained by provider (together referred to hereafter as "collectors") to collect any money that I owe to provider may contact me by telephone or text message at any number associated with my personal demographic information. I understand that this contact includes but is not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge, and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages.

COMMUNICATIONS REGARDING MY CARE:
I agree that provider may contact me by telephone or text message at any number associated with my personal demographic information for the purpose of care coordination, quality improvement activities, appointment reminders and wellness campaign reminders. I understand that this contact includes but is not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text

message. I understand, acknowledge and agree that provider may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages.

RELEASE OF INFORMATION AGREEMENT: I understand provider will generate, receive and store protected health information regarding my diagnosis and /or treatment. This information could include mental illness information, use of drugs and alcohol, or communicable diseases such as HIV/AIDS. I understand that the Notice of Privacy Practices provides information about how provider and its workforce may use and/or disclose my information for the purposes of treatment, payment, healthcare operations and otherwise required by law. I hereby authorize provider, in its discretion, to disclose any or all of the information in my medical records to any person, corporation or agency which is or may be liable for all or part of provider's charge or who may be responsible for determining the necessity, appropriateness, amount, or other matter related to treatment or charges, including, but not limited to, insurance companies, health maintenance organizations, preferred provider organizations, workers compensation carriers, welfare funds, and the Social Security Administration or its intermediaries or carriers. I further authorize provider, in its discretion, to disclose such information to its insurance carrier or carriers when so requested by such carrier and to my employer when said employer is liable for such charges.
This document shall be signed by the patient, his or her legal guardian, or by another competent individual due to the reason outlined below. The undersigned certifies that he/she/them has read or has been read this form, has received a copy, is the patient or authorized representative of the patient, and the conditions of admission are fully understood and accepted.

X_____

Signature of Patient

If patient is unable to consent or is a minor, complete the following: Patient is unable to consent because

_____

I am legally authorized to execute the above by virtue of my relationship to the patient as (circle one)

Father Mother Legal Guardian Other_____

X_____ **X**_____

Signature of Person Giving Consent Print Name of Person Giving Consent

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

NOTICE OF PRIVACY PRACTICES

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

Your Information.
Your Rights.
Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you.
- We will provide a copy or a summary of your health information, usually within 30 days of your request.
- We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete.
- We may deny your request, but we will tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way, for example, at a home or office phone, or to send mail to a different address.
- We will say yes to all reasonable requests.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or healthcare operations.
- We are not required to agree to your request, and we may deny it if it would affect your care.
- If you pay for a service or healthcare item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or healthcare operations with your health insurer.
- We will agree unless a law requires us to share that information.

Get a list of those with whom we have shared information
- You can ask for a list (accounting) of the times we have shared your health information for the six years prior to your request.
- This list will not include disclosures for treatment, payment, or healthcare operations.
- You may receive one free accounting per year. We may charge a reasonable, cost-based fee for additional requests.

Get a copy of this privacy notice
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive it electronically.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights.
- We will confirm that person's authority before taking any action.

File a complaint
- You may file a complaint if you believe your privacy rights have been violated.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference, tell us and we will follow your instructions.

You have the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are unable to tell us your preference, we may share information if we believe it is in your best interest.

We never share your information unless you give us written permission for:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

OUR USES AND DISCLOSURES

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

Healthcare operations
We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Payment
We can use and share your health information to bill and get payment from health plans or other entities.

Business associates
We may share your information with business associates who help us provide services. They are required to safeguard your information.

OTHER PERMITTED USES AND DISCLOSURES

We may use or share your health information in ways that contribute to the public good, including:
- Public health and safety activities
- Reporting abuse, neglect, or domestic violence
- Health oversight activities
- Research
- Organ and tissue donation
- Medical examiner or funeral director duties
- Workers' compensation
- Law enforcement or other government requests
- Responding to lawsuits or legal actions as required by law

SPECIAL PROTECTIONS FOR CERTAIN SUBSTANCE USE DISORDER RECORDS

Certain health information related to substance use disorder treatment may be protected by additional federal confidentiality rules under 42 C.F.R. Part 2.

These records may have stricter limits on how they are used and disclosed compared to other medical records.

In general, Part 2-protected records may not be used or disclosed in civil, criminal, administrative, or legislative proceedings against a patient without the patient's specific written consent or a court order.

Recipients of this information may also be restricted from redisclosing it without additional authorization or legal permission.

OUR RESPONSIBILITIES

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

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

CHANGES TO THIS NOTICE

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

Received by

X_____ _____

Signature Date

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

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____ Date of Birth:_____

Phone Number_____ Last Four Digits of Social Security Number:_____

Address_____

Email Adress_____

Authorization

I hereby authorize: _____
Entity, person(s), or class of persons

To disclose my protected health information to: Carriage Hill Family Care, PLC and its medical providers, employees and agents

Information to be Released

Date(s) of Service Requested: _____

☐ Entire medical record (including psychotherapy notes if applicable)

☐ Other (specify): _____

I understand that this information may include records related to mental health, communicable diseases, HIV/AIDS, and alcohol or drug use.

Purpose of Disclosure

☐ Continuity of care ☐ Personal use ☐ Insurance ☐ Legal

☐ Other: _____

Format of Records

☐ Paper ☐ CD ☐ Encrypted email ☐ Unencrypted email (not secure)

I understand that choosing unencrypted email carries risks, including unauthorized access or disclosure.

Right to Revoke

I understand that I have the right to revoke this authorization at any time by submitting a written request to Carriage Hill Family Care, PLC. I understand that the revocation will not apply to information that has already been released in reliance on this authorization.

Redisclosure

I understand that information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.

_____ _____
Patient Signature Date

_____ _____
Legal Representative, if not patient Date