

Apache Drive Children's Clinic

PATIENT REGISTRATION & DEMOGRAPHICS

Please print clearly. Complete one form per child.

Date: _____

PATIENT INFORMATION

Legal last name	Legal first name	Middle name	
_____	_____	_____	
Date of birth	Sex assigned at birth	Preferred name	Preferred language
_____	_____	_____	_____
Race (optional)	Ethnicity (optional)	Interpreter needed? Yes / No	
_____	_____	_____	
Home address / Apt.			

City	State	ZIP code	
_____	_____	_____	

PARENT / LEGAL GUARDIAN INFORMATION

Parent / guardian 1 - full name	Relationship to patient	
_____	_____	
Primary phone	Email	
_____	_____	
Employer	Social Security number	Date of birth
_____	_____	_____
Parent / guardian 2 - full name	Relationship to patient	
_____	_____	
Primary phone	Email	
_____	_____	
Employer	Social Security number	Date of birth
_____	_____	_____

EMERGENCY CONTACT (OTHER THAN PARENT / GUARDIAN ABOVE)

Full name	Relationship to patient	Phone
_____	_____	_____

INSURANCE & RESPONSIBLE PARTY

Primary insurance / Medicaid plan	Member / Medicaid ID	
_____	_____	
Policyholder name	Policyholder date of birth	Group number
_____	_____	_____
Secondary insurance	Member ID / Group number	
_____	_____	
Person responsible for account	Relationship to patient	Phone
_____	_____	_____

I confirm the information provided above is accurate to the best of my knowledge.

Parent / legal guardian signature: _____ Date: _____

APACHE DRIVE CHILDREN'S CLINIC

3203 Methodist Drive, Jonesboro, AR 72401
Phone: (870) 935-1800 | Fax: (870) 935-2917

PEDIATRIC PATIENT REGISTRATION FORM

For patients under age 18

6. PREFERRED PHARMACY

Pharmacy Name: _____	Phone: (____) _____
City / Location: _____	Cross Street (optional): _____

7. AUTHORIZED PERSONS / HIPAA RELEASE OF INFORMATION

Please list the person(s) you authorize Apache Drive Children's Clinic to communicate with regarding your child's care and/or protected health information, as permitted by law.

FIRST NAME	LAST NAME
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I understand that this authorization is voluntary and may be revoked in writing, except to the extent the clinic has already acted in reliance on it. This authorization is subject to applicable federal and state privacy laws.

Parent/Legal Guardian Signature: _____	Date: ____ / ____ / ____
Printed Name: _____	Relationship to Patient: _____

8. REGISTRATION ACKNOWLEDGMENT

I certify that the information on this registration form is correct to the best of my knowledge and that I have authority to provide information and sign for this minor patient. I understand that I should notify Apache Drive Children's Clinic when contact, insurance, guardianship, or authorization information changes. I understand that insurance coverage is not a guarantee of payment and that the financially responsible party may be responsible for charges not paid by insurance.

Parent/Legal Guardian Signature: _____	Date: ____ / ____ / ____
Printed Name: _____	Relationship to Patient: _____

FOR ADCC STAFF

Date Received: ____ / ____ / ____	Staff Initials: _____
Guardian ID Verified: ☐ Yes ☐ No	Insurance Card(s) Scanned: ☐ Yes ☐ No
Demographics Updated: ☐ Yes ☐ No	HIPAA Authorization Reviewed: ☐ Yes ☐ No



NO SHOW POLICY:

LOWERY BECK, M.D.

SASHA CLEMENTS, APRN

Quality care for our patients is our top priority. Please take a few minutes to read our No-Show Policy and sign it at the bottom. If you have any questions related to this policy, please let one of our staff know.

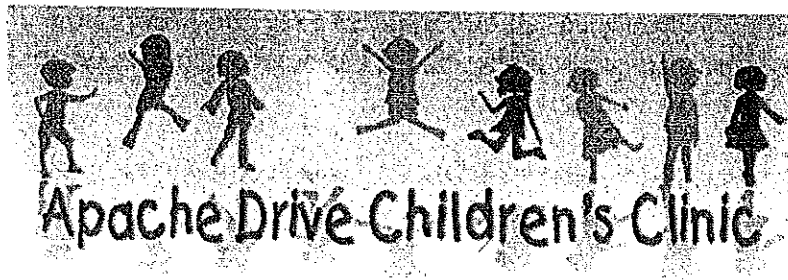
Our goal is to provide the best possible care for each of our patients and do so in a timely manner. Therefore, to make that possible, Apache Drive Children's Clinic has implemented a No-Show/Cancellation Policy.

We define a No Show as any patient who fails to show up for their appointment, fails to cancel their appointment at least 2 hours prior to their appointment time, or those who show up their appointment more than 10 minutes late, thus not being able to be seen. Our 10-minute grace period for appointments is not guaranteed. We reserve the right not to see your child if you are past your scheduled appointment time. **Each time you no-show an appointment for your child, our clinic will charge a \$20 No-Show Fee.**

After 2 No Show appointments, a patient may receive a letter in the mail notifying them of their previously missed appointments. Once the patient misses a 3rd appointment, he/she may be discharged from our practice. We understand that sometimes you simply cannot make it to your appointment. All we ask is that you respect our time and our other patients' time and call to cancel or reschedule your appointment. We appreciate your cooperation in this matter and look forward to providing your child with the best healthcare possible.

Patient Name: _____

Parent Signature and Date: _____



VACCINATION POLICY:

At Apache Drive Children's Clinic, we strongly support and recommend that all children receive vaccinations according to the immunization schedule recommended by the American Academy of Pediatrics (AAP) and the American Medical Association (AMA).

We believe that vaccinations are safe, effective, and an important part of protecting children, families, and our community from serious and potentially life-threatening communicable diseases. Vaccinations have been proven to reduce the spread of vaccine-preventable illnesses and help protect those who are unable to receive certain vaccines because of age or medical conditions.

We recognize that parents and legal guardians may have questions, concerns, fears, or uncertainty regarding vaccinations. We are committed to providing parents with accurate, evidence-based information and answering questions so that families can make informed decisions regarding their child's healthcare.

While we strongly support and recommend all vaccinations, Apache Drive Children's Clinic respects a parent's or legal guardian's right to make decisions regarding vaccinations for their child, subject to applicable federal, state, and local laws and regulations.

Parents and legal guardians who choose to delay or decline recommended vaccinations should understand that doing so may increase their child's risk of:

- Contracting vaccine-preventable diseases
- Developing serious complications from those diseases, including hospitalization, permanent disability, or death.
- Spreading communicable diseases to infants, other children, pregnant individuals, immunocompromised individuals, and others who may be particularly vulnerable.
- That they may directly contribute to an outbreak of vaccine-preventable diseases in our region.

- If our region experiences an outbreak of a vaccine-preventable disease, your child may be required to miss school, childcare, activities, or other opportunities due to their lack of vaccinations.

Vaccination does not guarantee that a child will never become ill; however, recommended vaccines substantially reduce the risk of many serious infectious diseases and their complications.

Parents or legal guardians who choose to delay, partially delay, or completely opt out of recommended vaccinations will be required to acknowledge that decision by signing a vaccination waiver that will be notarized at the time of the document signing. A new waiver may be required if vaccination decisions change or as otherwise determined by the clinic.

Apache Drive Children's Clinic will continue to strongly support and recommend routine childhood vaccinations and will provide families with current, evidence-based vaccination information to help them make informed healthcare decisions for their children.

Patient Name: _____

Parent Name: _____

Parent Signature: _____

Date: ____/____/____



FINANCIAL POLICY:

Payment in full is expected at the time of service. If an insurance or Arkansas Medicaid policy is effective, only the co-pay/co-insurance is collected. Personal Checks, Cash, Debit Cards, Master and Visa Cards are accepted.

Apache Drive Children's Clinic currently has a participating agreement with Arkansas Medicaid, ARKids First, and the following insurance companies: Blue Cross Blue Shield, USABLE, First Source, Health Advantage, Cigna, United HealthCare, all PASSE Insurances, and many others. We will file an insurance claim with these carriers and the insurance payment will be made to the clinic. If you are unsure if we participate in your plan, please check your benefit manual or contact your insurance company or employer. Our physician is on active staff with NEA Baptist Memorial Hospital. If your insurance plan requires you to use St. Bernard's Medical Center, our physician will not be able to treat you there. Please call your insurance company to verify which hospital is covered. We will file the insurance claim form on all hospital charges.

Medicaid and ARKids First patients are expected to bring their current card on the date of service. If our physician is not the PCP, you will be required to pay for the services provided at the time of check in. If Medicaid shows the coverage as inactive on the date of service, the patient will be responsible for payment of that day's charges. We will not refile claims with AR Medicaid, if the insurance is inactive on the date of service.

Financial Counseling is available with a patient account representative if you need assistance in complying with our financial policy. We will not discontinue services to patients who make appropriate, timely, monthly payments on their accounts. Accounts over 150 days old will be sent to an outside collections agency if payment arrangements have not been made with one of our account representatives. All accounts that are sent to collections will result in dismissal from our practice.

Parents with newborn babies must provide our clinic with proof of insurance by the time the baby is 8 weeks old. If you do not have insurance by that time, you will be asked to pay the full balance on the account and will be required to be self-pay for all visits moving forward until insurance is provided. If you are self-pay for a visit, we will not go back to file those charges to your insurance.

Patient Name: _____

Parent Signature and Date: _____



ER/URGENT CARE POLICY:

LOWERY BECK, M.D.

SASHA CLEMENTS, APRN

Our practice values the opportunity that we have to treat your child for all their healthcare needs. We realize that at times it may be necessary to take your child to see another healthcare provider such as an Urgent Care or ER. However, our providers ask that you keep that to a minimum and only do so if instructed to by our staff or on-call service.

Reasons to visit an ER should be due to a true emergency. This would include things such as a broken bone, if your child was involved in a car accident, if they are having trouble breathing, if they need stitches and our office is closed, a fever of 105 or greater that you cannot get under control, etc. Urgent Care should not be used unless our staff or on call service advises you to take your child. We ask that you bring your child to see one of our providers above, taking them anywhere else.

Our practice offers a walk-in-sick call Monday-Friday from 7:30am-9:00am (No appointment is needed during this time). We also offer same day appointments and appointments until 4:30pm Monday-Friday. Our practice offers after-hours care as well. You can call our main number, 870-935-1800, after 5:00pm and you will be directed to a nurse at Arkansas Children's Hospital that can give you medical advice on your child.

Our practice monitors our patient's use of the ER and Urgent Cares. We receive reports about when a patient of ours is seen at another healthcare facility and the reason for the visit. If you utilize other healthcare settings for non-emergent reasons, or without being instructed to do so, you will receive a warning letter in the mail. If you continue to use the ER or Urgent Cares after a warning letter has been mailed out to you, your child will be discharged from our practice.

Patient Name: _____

Parent Signature/Date: _____