

Apache Drive Children's Clinic

NEW PATIENT QUESTIONNAIRE

Patient Name: _____

Patient DOB: ____ / ____ / ____

1. Please name your child's previous primary care provider (PCP):

2. What is your reason for looking for / needing a new PCP?

3. In the last year, how many times has your child visited an urgent care or emergency room for care?

☐ 0-1

☐ 2-4

☐ 5-6

☐ 8 or more

4. Has your child ever been discharged from any medical provider in the past? If yes, please list the reason for discharge.

☐ YES ☐ NO

5. Does your child receive childhood vaccinations? If yes, are they up to date? If no, please provide the reason they are not receiving vaccinations.

☐ YES ☐ NO ☐ UP TO DATE

6. Has your child been diagnosed with autism, ADHD, anxiety, and/or depression?

☐ YES ☐ NO

7. If you answered YES to Question 6, please list any medications they take for these conditions:

8. If your child is not currently taking medication for the conditions listed above, do you plan to discuss starting medication at the initial new-patient visit?

☐ YES ☐ NO ☐ NOT APPLICABLE

For Office Use Only

Reviewed by: _____ Date: ____ / ____ / ____

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

APACHE DRIVE CHILDREN'S CLINIC

PEDIATRIC MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Place of Birth: _____

BIRTH & NEWBORN HISTORY

Problems during pregnancy? _____

Type of delivery: ☐ Vaginal ☐ C-Section - Repeat ☐ C-Section - Emergency ☐ Other

Problems during delivery? _____

Significant problems during the first 2 weeks of life? _____

Has this child ever received a blood transfusion or blood products? ☐ Yes ☐ No

Is this child currently taking any medications? ☐ Yes ☐ No

If yes, please list: _____

IMMUNIZATIONS & DEVELOPMENT

Has this child received immunizations? ☐ Yes ☐ No Are immunizations up to date? ☐ Yes ☐ No ☐ Unsure

For Infants:

Feeding: ☐ Breastfeeding ☐ Formula feeding Formula/brand: _____

Do you feel your baby is developing normally? ☐ Yes ☐ No

If no, please describe your concerns: _____

SCHOOL-AGE CHILD

How is your child doing in school? _____

School attended: _____ Current grade: _____

Any significant behavioral or emotional concerns? _____

If your child is over 10 years of age, have they received their 2nd MMR? ☐ Yes ☐ No ☐ Unsure

FEMALE ADOLESCENT

Has menstruation started? ☐ Yes ☐ No Age at first period: _____

Periods: ☐ Regular ☐ Irregular Flow: ☐ Heavy ☐ Normal ☐ Light

PATIENT'S MEDICAL & SURGICAL HISTORY

MONTH / YEAR	PAST MEDICAL PROBLEMS	MONTH / YEAR	SURGERIES

ALLERGIES & PARENT HEALTH

Does this patient have any known allergies? ☐ Yes ☐ No

Medications: _____ Other: _____

Mother's health / health problems: _____

Father's health / health problems: _____

HEALTH HISTORY OF BROTHERS / SISTERS

Name of Brother or Sister	Age	M	F	Health - Include Past/Present Problems

FAMILY HISTORY

Does or has any blood relative of this child have or had any of the following? Check all that apply.

- | | | | |
|---|--|---|---|
| ☐ Diabetes | ☐ Cancer | ☐ Bleeding Disorder | ☐ Anemia |
| ☐ Kidney Disease | ☐ Tuberculosis | ☐ Heart Disease | ☐ Stroke |
| ☐ High Cholesterol | ☐ High Blood Pressure | ☐ Arthritis | ☐ Lupus |
| ☐ Rheumatic Fever | ☐ Asthma | ☐ Psychiatric Disorder | ☐ Crohn's / Ulcerative Colitis |
| ☐ Cystic Fibrosis | ☐ Seizures / Epilepsy | ☐ Hearing Impairment | ☐ Vision Impairment |

ARKANSAS MEDICAID PRIMARY CARE PHYSICIAN MANAGED CARE PROGRAM
PRIMARY CARE PHYSICIAN SELECTION AND CHANGE FORM

Member Information:

First Name _____ Last Name _____ Middle Initial _____
Medicaid ID# _____ Social Security # _____
Birth Date (mm/dd/yyyy) _____
Mailing Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Email address _____

Requested New Doctor (Primary Care Provider):

I have picked the three (3) physicians named below in order of my preference to be my primary care physician. I understand only one (1) of them will be my primary care physician.

1.	<u>Marvin Lowery Beck</u> Doctors first and last name	<u>119050001</u> Medicaid Provider ID#	_____ Date of assignment
2.	<u>Sasha Clements</u> Doctors first and last name	<u>29434758</u> Medicaid Provider ID#	_____ Date of assignment
3.	_____ Doctors first and last name	_____ Medicaid Provider ID#	_____ Date of assignment

Reason for Request to Assign/Change Doctor (Primary Care Provider)
Choose all that apply. Select at least one.

- ☐ New Member – made 1st time selection
- ☐ Already patient with requested PCP
- ☐ Requested PCP already sees family member
- ☐ Member preference
- ☐ Member moved
- ☐ PCP hours didn't fit member need
- ☐ Quality of care
- ☐ Office wait times are too long
- ☐ Takes too long to get an appointment
- ☐ Office too far away/ hard to get to
- ☐ Language / communication barrier
- ☐ Other (please specify) _____

Signatures:

Member Signature (or Legal Guardian if a minor) _____

Printed Name of Member (or Legal Guardian if a minor) _____

Date (mm/dd/yyyy) _____

APACHE DRIVE CHILDREN'S CLINIC

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

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Internal Note: A separate original authorization should be signed for each request for release of information.

TO / FROM: Apache Drive Children's Clinic
3203 Methodist Drive
Jonesboro, AR 72401

Contact: _____

TO / FROM: _____

Address: _____

Phone: _____

Fax: _____

I, _____, parent/guardian of the patient named below, authorize Apache Drive Children's Clinic (ADCC) to obtain from or release to the person/agency listed above the pertinent medical, social, or other information identified below. I understand that this information is confidential and will be used for the benefit of the patient. I also understand that information released to another party may be subject to re-disclosure by the recipient, and ADCC is not responsible for such re-disclosure.

DOCUMENTS / INFORMATION TO BE RELEASED

1. _____
2. _____
3. _____
4. _____

PURPOSE FOR RELEASE (CHECK ALL THAT APPLY)

☐ At the request of patient or parent/guardian

☐ Per ADCC discretion or needs

Patient's Name: _____

DOB: ____ / ____ / ____

Signature of Parent / Guardian: _____

Date: ____ / ____ / ____



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 care 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: _____