NEW PATIENT QUESTIONAIRE:

PATIENT NAME: _____

PATIENT DOB: ____/_____/_____

1) PLEASE NAME YOUR CHILD'S PREVIOUS PCP: _____

2) WHAT IS YOUR REASON FOR LOOKING/NEEDING A NEW PCP?

_____

_____

3) IN THE LAST YEAR, HOW MANY TIMES HAS YOUR CHILD VISITED AN URGENT CARE/ER FOR CARE?

A) 0-1 C) 5-6

B) 2-4 D) 8 OR MORE

4) HAS YOUR CHILD EVER BEEN DISCHARGED FROM ANY MEDICAL PROVIDER IN THE PAST? PLEASE LIST THE REASON FOR DISCHARGE IF YOU ANSWER YES.

YES OR NO _____

5) DOES YOUR CHILD RECEIVE CHILDHOOD VACCINATIONS? IF YOU ANSWER YES, ARE THEY UP TO DATE ON THEIR VACCINATIONS? IF YOU ANSWER NO, PLEASE PROVIDE A REASON THAT THEY ARE NOT RECEIVING VACCINATIONS.

YES OR NO _____

6) HAS YOUR CHILD BEEN DIAGNOSED WITH AUTISM, ADHD, ANXIETY/DEPRESSION?

YES OR NO

7) IF YOU ANSWER YES TO QUESTION 6, PLEASE LIST ANY MEDICATIONS THAT THEY TAKE FOR THESE CONDITIONS? _____

8) IF NOT ON ANY MEDICATIONS FOR THE ABOVE CONDITIONS, DO YOU PLAN TO DISCUSS STARTING MEDICATION AT YOUR INITIAL NEW PATIENT VISIT? YES OR NO

APACHE DRIVE CHILDREN'S CLINIC
Patient Registration

Patient: Last Name:_____ First Name:_____ MI: _____

Sex: Male or Female DOB:___/___/___ SSN:_____

Primary Language:_____ Secondary Language: _____

Ethnicity: Hispanic/ Non-Hispanic/ Unknown/ Decline to Specify

Race: Asian/ American Indian-Alaskan/ African American/ Pacific Islander/ White/ Middle East/ Other/ Decline to Specify.

School or Daycare: _____

Home Address:

_____

(Street) (City) (State & Zip)

If you also have a PO Box (Include zip code)

_____

Emergency Contact: (other than parents):

_____ _____

Name and Relationship to Child Phone Number

Parent 1 or Guardian:_____
Relationship to patient:_____
Lives with patient: Yes / No If No, Address_____
Date of Birth: ___/___/____ Social Security Number: ____-____-_____
Home Phone: (____)-____-_____ Cell Phone:(____)-____-_____ Carrier (_____)
Email: _____ Employer: _____
Work Phone Number: (____)-____-_____

Parent 2 or Guardian:_____
Relationship to patient:_____
Lives with patient: Yes / No If No, Address_____
Date of Birth: ___/___/____ Social Security Number: ____-____-_____
Home Phone: (____)-____-_____ Cell Phone:(____)-____-_____ Carrier (_____)
Email: _____ Employer: _____
Work Phone Number: (____)-____-_____

INSURANCE:

Insurance Carrier: _____
Policy Holer's Name: _____
Policy Holder's Gender: M or F
Policy Holder's Relation to Patient: _____
Policy Holder's DOB: _____/_____/_____
Policy Holder's Social Security Number: _____
Insurance ID Number: _____
Group Number: _____

PRIVACY/HIPAA:

The State of Arkansas recognizes the genetic mother and genetic father to hold the rights of medical disclosure until the age of 18. This form is for extending medical disclosure rights to other parties.

I AUTHORIZE APACHE DRIVE CHILDREN'S CLINIC TO DISCLOSE PERSONAL HEALTH INFORMATION TO THE FOLLOWING:

NAME:	RELATIONSHIP TO PATIENT:

CUSTODY: (This section pertains to parents/guardians who are divorced or separated)

Who has legal custody of the patients? (Please include relationship to patient)

_____

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? YES / NO

If yes, please explain and provide a copy of any legal documentation that supports this restriction.

_____

MEDICAL HISTORY

PATIENT NAME _____ DATE OF BIRTH _____
Place of Birth _____
Problems during pregnancy ? _____
Type of Delivery: Vaginal ____ C/Section: repeat _____ emergency _____
Problems during Delivery : _____
Significant problems during newborn period (1st 2 weeks): _____
Has this child ever received a blood transfusion of any blood products ? YES NO
IS THIS CHILD CURRENTLY TAKING ANY MEDICATION ? YES NO. If yes please list:

_____
_____
_____

Has this child had any immunizations? _____ If yes, are they up to date? _____
IF CHILD IS AN INFANT:
Breast feeding _____ Formula Feeding _____ if so which formula? _____
Do you feel your baby is developing normally? _____ if NO what are your concerns ?

_____
IF YOUR CHILD IS OF SCHOOL AGE:
How is your child doing in school? _____
Where does he attend school? _____ Current Grade _____
Are there any significant behavioral or emotional problems in your opinion? _____

_____
If your child is over10 years of age,did they received their 2nd MMR? YES NO
IF PATIENT IS FEMALE ADOLESCENT:
Is she having periods yet? _____ How old was she at menarche (first period)? _____
Periods are: _____Regular _____Irregular FLOW: _____Heavy _____Normal _____Light

PATIENTS MEDICAL HISTORY:

MONTH / YEAR	PAST MEDICAL PROBLEMS	MONTH / YEAR	SURGERIES

Does this patient have any known allergies? YES NO
If yes please specify: 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

DOES OR HAS ANY BLOOD RELATIVE OF THIS CHILD HAVE OR HAD ANY OF THE FOLLOWING ? :
__Diabetes __Cancer __ Bleeding Disorder __Anemia __ Kidney Disease __ Tuberculosis
__ Heart Disease __ Stroke __ High Cholesterol __ High Blood Pressure __ Arthritis __ Lupus
__Rheumatic fever __ Asthma __Psychiatric Disorder __Crohns/Ulcerative Colitis
__ Cystic Fibrosis __Seizures/Epilepsy __ Hearing Impaired __ Vision Impaired

Apache Drive Children's Clinic

Apache Drive Children's Clinic
3203 Methodist Drive Jonesboro, AR 72401
Phone: 870-935-1800 Fax: 870-935-2917

AUTHORIZATION OF RELEASE OF CONFIDENTIAL INFORMATION:

Internal Note: An original authorization shall be signed for each request of 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, give ADCC permission to obtain from or give to the above named agency/person, pertinent social, medical, other information listed below. I understand that this information is confidential and will only be used for the benefit of the patient. I understand that this information may be subject to re-release by the recipient without the knowledge or consent of ADCC and that ADCC is in no way responsible for this action.

DOCUMENTS 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:** ___/___/____

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 on
(1) of them will be my primary care physician.

1. Marvin Lowery Beck — Doctors first and last name; 1190500001 — Medicaid Provider ID#; _____ — Date of assignment
2. _____ — Doctors first and last name; _____ — 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.

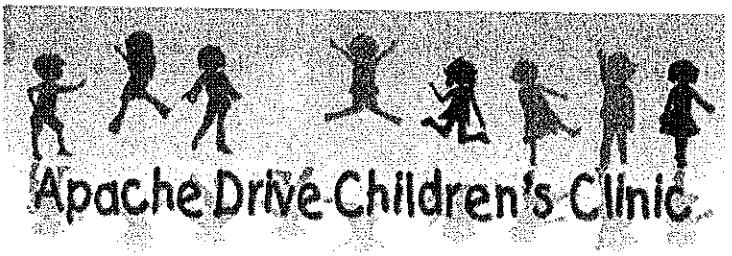
- ☐ New Member – made 1st time selection
- ☐ Already patient with requested PCP
- ☐ Requested PCP already sees family member
- ☐ Member preference
- ☐ Member moved
- ☐ PCP hours didn't fit member need
- ☐ Quality of care
- ☐ Office wait times are too long
- ☐ Takes too long to get an appointment
- ☐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



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: _____