THE CHILDREN'S CLINIC OF CONWAY AND GREENBRIER

Patient 1 Intake form

Patient name:_____
First name M.I. Last name

Gender:
☐ Male ☐ Female
☐ Other:

Date of Birth: _____ SSN#: _____

Race/Ethnicity: ☐ Amer. Ind./Alaska Native ☐ Asian ☐ Black/African Amer. ☐ Hawaiian/Pac Isl ☐ White ☐ Other:
Primary Language: ☐ English ☐ Spanish ☐ Other: _____

If in foster care, Care Worker: _____

Address: _____

_____

Guardian 1 name:_____ DOB: _____ SSN: _____

Guardian 1 Relationship to Patient:_____ Guardian 1 Employer:_____

Guardian 1 Email:_____ Guardian 1 Phone #:_____

Guardian 2 name:_____ DOB: _____ SSN: _____

Guardian 2 Relationship to Patient:_____ Guardian 2 Employer:_____

Guardian 2 Email:_____ Guardian 2 Phone #:_____

Patient 2 Intake form

Patient name:_____
First name M.I. Last name

Gender:
☐ Male ☐ Female
☐ Other:

Date of Birth: _____ SSN#: _____

Race/Ethnicity: ☐ Amer. Ind./Alaska Native ☐ Asian ☐ Black/African Amer. ☐ Hawaiian/Pac Isl ☐ White ☐ Other:
Primary Language: ☐ English ☐ Spanish ☐ Other: _____

If in foster care, Care Worker: _____

☐ Address and Guardian information is same as Patient 1

☐ Address/Guardian information is different:

Patient 3 Intake form

Patient name:_____
First name M.I. Last name

Gender:
☐ Male ☐ Female
☐ Other:

Date of Birth: _____ SSN#: _____

Race/Ethnicity: ☐ Amer. Ind./Alaska Native ☐ Asian ☐ Black/African Amer. ☐ Hawaiian/Pac Isl ☐ White ☐ Other:
Primary Language: ☐ English ☐ Spanish ☐ Other: _____

If in foster care, Care Worker: _____

☐ Address and Guardian information is same as Patient 1

☐ Address/Guardian information is different:

Preferred Pharmacy (name): _____

Divorce, Separation, Custody

If the parents are divorced, separated, or do not have custody of Patient 1, 2, or 3, please fill out:

Who has primary custody _____

Are there legal restrictions on parents consenting to medical treatment or obtaining medical information? _____

Please provide any legal/court documents for our records

We cannot discuss patient's care with anyone who is not listed on your child's account. If anyone who is not a listed guardian needs to bring the child in to the clinic, they must be listed on our proxy form.

Pertinent Past and Family Medical History

Please list any pertinent past medical history for the patient's listed on the previous page and include any pertinent family medical history below

_____

_____

_____

_____

_____

_____

_____

Authorizations and Consents

Authorize use of medical information

I authorize the release of any personal health information necessary to process insurance claims for services rendered and any other avenues used for collection of balances. I authorize any benefits on my behalf and request that payment be made directly to the practice. I authorize access to the pharmacy benefit manager, PBM, as needed by my physician (provider) to review medications prescribed outside the practice. I understand that I am responsible for the balance of my account. Upon receipt, if I should receive payment from my insurance company, I also understand that I am responsible for my co-payment, deductibles, or balances as determined by my insurance carrier.

HIPAA Policy

I have received a physical copy or have been offered an electronic copy of this medical office's HIPAA policy and have or will review this policy. I understand that a copy of this policy can be provided upon request and is available at the clinic's website, www.thechildrensclinicscg.com.

Non-Discrimination Policy

I have received a physical copy or have been offered an electronic copy of this medical office's non-discrimination policy and have or will review this policy. I understand that a copy of this policy can be provided upon request and is available at the clinic's website, www.thechildrensclinicscg.com.

Consent to Treat

I _____, parent or legal guardian of _____,
Guardian Patient 1

_____, and _____, do hereby consent
Patient 2 Patient 3

to receive medical care from The Children's Clinic of Conway and Greenbrier and its healthcare providers. I understand that this may include examinations, diagnostic tests, treatments, and procedures deemed necessary by my provider for my child's health needs.

*The signature below covers the above authorizations and consents for all patients listed on the first page.

_____ Date: _____
Signature

Vaccine Policy

The Children's Clinic of Conway and Greenbrier, along with the Arkansas Department of Health, the American Academy of Pediatrics, the Centers for Disease Control, the World Health Organization, and numerous other medical groups, organizations, hospitals, and clinics world wide acknowledge that modern vaccines provide tremendous benefit in the prevention and control of certain serious diseases. As such this clinic, along with many other clinics, has a vaccine policy that patients and families must abide by in order for this clinic to provide medical services to its patients. Waiver forms and exemptions from the state cover childcare facilities, public school, private school, as well as colleges and universities. These forms do not pertain to a medical facility such as this medical clinic.

- ►I understand that the clinic has a vaccine policy. This vaccine policy requires that the patients under the clinic's care are following the recommended AAP schedule for vaccinations or one of our providers have approved an alternate schedule.

- ►I understand that if I choose to refuse all vaccines that I will be required to find a new medical office that is aligned with my vaccination preferences/beliefs. This vaccine policy is required by the clinic in order to keep our patient population and the medical staff safe from vaccine preventable illnesses.

- ►I understand that The Children's Clinic providers may elect to continue seeing my child despite my vaccine refusal if the providers feel it is in the best interest of my child to have a stable medical home. I understand that this status will be reviewed periodically and, once safe to do so, I may no longer be able to bring my child to The Children's Clinic due to my refusal to vaccinate my child.

- ►I understand that my child and I may be required to wait in my car (vs the waiting room) to prevent other children from getting sick from a vaccine preventable illness (for example, pertussis)

- ►I understand that I will receive a 'vaccine packet' providing information about vaccine preventable illness and that there is some required legal paperwork that needs to be completed annually while my child remains under the care of The Children's Clinic.

I, _____, acknowledge that I have read the above summary of the clinic's vaccine policy.

Below is my vaccination intention for the children listed on the first page (Patient 1, Patient 2, and Patient 3). I understand my current intention is not legally binding and the clinic agrees it will not use this information to coerce or require that my child receive any vaccine at any time. I understand that, despite my intensions listed below, it is my (or another legal guardian or a listed proxy) decision whether to consent to vaccine administration at the time of the visit and it is my legal right as a legal guardian to refuse medical treatment, including vaccines, I do not agree with.

Patient 1: ☐ Follow AAP schedule for full vaccination ☐ Delay certain vaccines or follow alternate schedule ☐ Refuse all vaccines

Patient 2: ☐ Follow AAP schedule for full vaccination ☐ Delay certain vaccines or follow alternate schedule ☐ Refuse all vaccines

Patient 3: ☐ Follow AAP schedule for full vaccination ☐ Delay certain vaccines or follow alternate schedule ☐ Refuse all vaccines

Link to AAP vaccine schedule and information

*The signature below covers the above authorizations and consents for all patients listed on the first page.

_____ Date: _____

Signature

Patient Rights and Responsibilities

The following statement of your rights and responsibilities is presented as the policy of The Children's Clinic of Conway & Greenbrier but does not presume to be a complete representation of all mutual rights and responsibilities.

You have the right:

- To impartial access to the medical resources of The Children's Clinic of Conway & Greenbrier without regard to race, color, national origin, age, sex, handicapping or disabling condition, spiritual or ethical beliefs or source of payment.
- To receive considerate, respectful care, which always recognizes your child's personal dignity and under all circumstances.
- To participate in decisions involving your child's care. Except in emergency, your child shall not be subjected to any procedure without your voluntary, competent, and understanding consent or the consent of your legally authorized representative.
- To refuse treatment to the extent permitted by law and to be informed of the consequences of that refusal.
- To instructional and educational information about your child's medical treatment in a language and terms that you understand.
- To the confidential treatment of and personal access to your child's medical record.
- To know who is responsible for providing your child's direct care and to receive information concerning your child's continuing health care needs and alternative for meeting those needs.

You have the responsibility:

- To give your provider and The Children's Clinic of Conway & Greenbrier staff complete and accurate information about your child's condition and care.
- To follow instructions of your provider and the staff of The Children's Clinic of Conway & Greenbrier and to keep appointments relative to your child's care.
- To make it known whether you clearly understand planned actions and treatment and what is expected of you.
- To report unexpected changes in your child's condition to your provider or staff of The Children's Clinic of Conway & Greenbrier.
- To accept the financial obligations associated with your child's care.
- To advise your provider or any office staff members of any dissatisfaction you may have regarding your child's care.
- To be considerate of other patients and of staff members who are caring for your child.
- To bring a current copy of any advance directives at the time of the first visit to be placed in your medical record.

*The signature below covers the above authorizations and consents for all patients listed on the first page.

_____ Date: _____

Signature

The Children's Clinic of Conway and Greenbrier Financial Policy

Professional services are charged to the patient, not the insurance company. This office does not accept responsibility for collecting your insurance claim, or for negotiating a settlement on a disputed claim.

I hereby authorize The Children's Clinic of Conway and Greenbrier to furnish information to insurance carriers concerning my child's illness and treatments and I hereby assign to the physician all payment for medical services rendered by insurance.

The patient will be responsible for all co-payments, deductibles, and co-insurances which are due at the time of service.

It is the patient's responsibility to keep us updated on correct insurance information. If you do not tell us about changes or pending changes, you could incur charges that may or may not be covered by your insurance.

We verify most insurances as a courtesy, however, there is no way we can determine all your benefits so we cannot guarantee what may or may not be covered by your plan until the claim is processed. Examples may include:

- Well Child exams and immunizations. Not all plans cover these. Some may only cover to a certain age and some only cover up to a certain dollar amount. Some plans may pay 100% and others may still charge copay. Please be familiar with your plan to know what may or may not be covered as you will be responsible for any charges incurred.
- Some procedures, such as laceration repair and wart removal may be processed at a different benefit level other than just a routine office visit and could be subject to deductibles and co-insurances.
- Some plans exclude certain diagnoses. There is no way we can make that determination when we check eligibility, and you may be responsible for those visits.
- Diagnoses such as ADHD may be covered by mental health benefits and could be subject to deductibles.

Statements are mailed out weekly. Payment is due within 15 days of receipt. Any balances over 90 days with the patient receiving at least 3 statements with no activity can be turned over for collections and you could be discharged from the clinic.

We do not get involved in separated and divorced parents' financial obligations. We will send the statement to whichever parent is listed as the guarantor and we hold both parents responsible for any outstanding balances.

*The signature below covers the above authorizations and consents for all patients listed on the first page.

_____ Date: _____

Signature

Credit Card Information

I authorize The Children's Clinic of Conway & Greenbrier to store my credit card information on file. I authorize The Children's Clinic to use this card for each visit up to a maximum of $250.

*The signature below covers the above authorizations and consents for all patients listed on the first page.

_____ Date: _____

Signature

Proxy Form

Legally, only guardians listed on the first page of this document are allowed to bring your child to the clinic and make medical decisions for them. This form is to allow those who are not guardians listed above to bring your child to the clinic and make medical decisions for your child. We cannot see your child if someone brings your child to the clinic who is not listed as a guardian or on this proxy form.

Please fill out the following information for those you would like to give permission to bring your child/children to our clinic and to make medical decisions for your child:

Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient

I appoint the person(s) listed above as my proxy decision maker for consenting to non-urgent medical care for my children listed as Patient 1, Patient 2, and Patient 3 and listed below. I have the legal right to delegate such consent to the proxy decision maker, who is an adult and legally and medically competent to exercise the authority so delegated. Be advised that protected health information may be shared with the proxy to facilitate informed decision making.

Additional children covered by this proxy not listed on the first page of this document:

Child's Name	Child's Date of Birth
Child's Name	Child's Date of Birth
Child's Name	Child's Date of Birth

Identify any limitations to the decisions the proxy can make or the medical information that can be shared with the proxy:

_____

_____

_____

Identify any time limits to when the above proxy or proxies can make decisions or access medical information:

_____

_____

_____

*The signature below covers the above authorizations and consents for all patients listed on the first page.

_____ Date: _____

Signature

Missed Appointment Policy

The Children's Clinic of Conway & Greenbrier sees patients by scheduled appointment and for emergencies. We try to see all those who need appointments within an appropriate amount of time allotted for each visit.

We reserve time for each patient, and if the patient does not come to the appointment the result is lost revenue to the clinic and a missed opportunity for someone else to be given the appointment time.

To address the problem of frequent missed appointments (often multiple missed appointments within a family) and provide appointments for as many patients as possible, we have instituted a financial penalty for people who repeatedly miss appointments.

Arriving 20 minutes late to an appointment is the same as missing an appointment, and in most cases, you will be asked to reschedule the appointment and pay the fee.

Canceling an appointment less than an hour before the appointment is the same as a missed appointment. Call the day before or early in the day if you need to cancel or reschedule an appointment.

Missed appointments within a family are tracked together. If two children each miss one appointment, it counts as two missed appointments for your family.

I understand that for certain missed appointments (see below) I will be charged a $35 or $50 fee, PAYABLE BEFORE FURTHER APPOINTMENTS ARE SCHEDULED, and that if I repeatedly miss appointments, I will be asked to find another doctor for my children. I understand that Medicaid, ARKids, and private insurance do not cover these costs and I will be expected to pay the clinic directly.

Missed Appointment Fee Schedule:

- New patient missed appointment: $50
- Second missed appointment: $35
- Third missed appointment: $35 and you may be asked to see a new provider at a different clinic

*The signature below covers the above authorizations and consents for all patients listed on the first page.

_____ Date: _____

Signature

Telephone, Cell phone, and Electronic Communication

I authorize The Children's Clinic of Conway and Greenbrier (also known as Conway Children's Clinic and Greenbrier Children's Clinic) to use my provided phone number(s) and email address, included in the new patient paperwork and/or listed in the electronic medical record, for the following:

- Appointment reminders
- Follow-up reminders
- Patient communication
- Billing communication
- Clinical reminders

These communications may be subject to carrier charges, if applicable, per the phone or mobile plan provided by the caregiver's cell phone carrier.

The Children's Clinic of Conway and Greenbrier will treat any email address or phone number I provide as my private email address and phone number and this contact information will not be shared by any third-party entities.

Initials for Consent _____

Patient Portal

The Children's Clinic has a patient portal via InteliChart. InteliChart provides a user-friendly interface that is compatible with most web browsers and is mobile friendly. There are also apps available for both iPhone and Android operating systems. Electronic communication, listed above, will be used to enhance our patient care. Communication with The Children's Clinic, including appointment requests, refill requests, and general messages is preferred through the patient portal.

For security, InteliChart requires any new registration with their service to be via invitation only. This invitation will be sent by an employee of The Children's Clinic.

The patient portal invitation will be sent via the method listed below or via the phone number for guardian 1 on page one of the new patient paperwork packet:

☐ Email address: _____

☐ Cell Phone (via text)*: _____

*Carrier charges may apply

Invitations are patient specific. Any siblings that need to be added to the portal need their own invitation. Unless you indicate otherwise, all children listed above will receive a portal invitation.

□ Do not send portal invitations for the patients listed above on page one

List additional siblings not listed above who need portal account access:

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Date: _____

Parent/Guardian Signature