ARKANSAS PEDIATRIC CLINIC

MIDTOWN
500 South University Avenue
Suite 317
Little Rock, AR 72205

BRYANT
1412 Woodland Drive
Bryant, AR 72022

MAUMELLE
11749 Maumelle Boulevard
North Little Rock, AR 72113

WEST
16115 St. Vincent Way
Suite 320
Little Rock, AR 72223

Anthony D. Johnson, M.D.
Anton L. Duke, M.D.
Stacy L. Sax, M.D.
Paige Fenner, APRN

Lori E. Montgomery, M.D.
Scott M. Sanders, M.D.
Sarah C. Bone, M.D.
Jodi Haltom, MNSc, APRN, FNP-C

Eugene Lu, M.D.
Kristi M. Hawkins, M.D.
Deena Garner, APRN

Patient Information Form

Patient's Full Name: _____ Date of Birth: _____ (Male)___ (Female)___

Race (please circle one): □American Indian or Alaska Native □Asian □Black or African American □Native Hawaiian or Other Pacific Islander □White

Ethnicity (please circle one): □Hispanic or Latino □Not Hispanic or Latino

Address _____
Street Apt # City State Zip Code County

Cell phone number: (_____)_____ Alternate phone number: (_____)_____

Email Address (please print clearly):_____

I (mother/father) of _____ authorize medical records to be emailed to the above email address.
□Yes □No

Primary Care Physician: _____

Responsible party:_____

Father's name:_____ Mother's Name:_____

Social Security No:_____ Social Security No:_____

Date of Birth:_____ Date of Birth:_____

Marital Status: (Married)____ (Divorced)_____ (Single)_____ Mother's Maiden Name:_____

Please list the names of other children and date of birth:

_____

_____

_____

Emergency Contact (not living at same address as patient):

Name:_____ Relation to child:_____

Telephone No: ( )_____ Address:_____

I give permission for Arkansas Pediatric Clinic to treat my child._____
Signature Date

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Authorization for Alternate Consent

EVEN IF YOU DO NOT WANT ANYONE ON THE LIST. PLEASE GO AHEAD AND SIGN/DATE THIS FORM.

I, _____ am the [mother, father, or legal guardian]
(Parent or Legal Guardian's Name)

of _____ Date of Birth: _____
(Child's Name)

By signing below, I hereby authorize Arkansas Pediatric Clinic to provide medical services to my child as deemed necessary by the physicians at Arkansas Pediatric Clinic upon obtaining this written consent of anyone of the following individuals that I have listed below:

_____ (Name of person you are allowing to bring the child in)	_____ (Relationship to the child)
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_____ (Name of person you are allowing to bring the child in)	_____ (Relationship to the child)
_____ (Name of person you are allowing to bring the child in)	_____ (Relationship to the child)
_____ (Name of person you are allowing to bring the child in)	_____ (Relationship to the child)
_____ (Name of person you are allowing to bring the child in)	_____ (Relationship to the child)

I agree to pay for the charges billed for any and all services provided to my child by Arkansas Pediatric Clinic based upon the consent of anyone of the above named individuals. I understand and agree that this authorization will remain in effect until I revoke this authorization by a delivered written notice of such revocation to Arkansas Pediatric Clinic.

_____
(Signature of Parent or Legal Guardian)

_____
(Print Name of Parent or Legal Guardian)

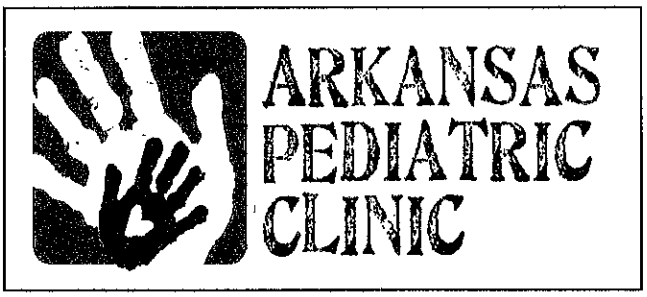
_____
(Date)

[SEAL]
STATE OF ARKANSAS

County of _____

Subscribed and sworn to before me, a Notary Public, this _____ day of _____, 20_____

_____
(Notary Public)



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Arkansas Pediatric Clinic Policies

Patient Name: _____ Date of Birth: _____

Insurance Information

I authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be fully responsible for all lawful debts, included but not limited to co-payments and deductibles due under my insurance plan, incurred by my child for services received from Arkansas Pediatric Clinic whether covered by insurance or not. I also understand that if I have a primary insurance, I will still be responsible for all charges not covered by the secondary insurance including Medicaid.

Primary Insurance: _____

Secondary Insurance: _____

Signature: _____ Date: _____

Appointment Policy

We appreciate the trust you have placed in us and will provide the quality of medical care you expect for your child. Our office procedures have been designed for your comfort. We take great pride in our ability to provide your child with optimal medical care.

We understand that circumstances occur that interfere with you keeping certain appointments; however, we do kindly ask that you give our office two hour notice prior to your appointment if you will be unable to attend making it available for another patient. After three or more missed appointments Arkansas Pediatric Clinic reserves the right to terminate our doctor-patient relationship. Please feel free to contact our office at any time should you have any questions or concerns. We look forward to seeing you again and serving your child's medical needs.

Signature: _____ Date: _____

HIPAA Agreement

By my signature below, I acknowledge that I have received a copy of the Arkansas Pediatric Clinic, PLLC Notice of Privacy Practices.

Signature: _____ Date: _____

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

ALL ELEMENTS ARE REQUIRED PRIOR TO INFORMATION BEING RELEASED

Patient Name: _____ **Date of Birth:** _____

1. **Physician/Facility** authorized to disclose the information? **Name:** _____
   Complete Address: _____
   Phone Number: _____ **Fax Number:** _____
2. Who is authorized to receive the information? **Name: Arkansas Pediatric Clinic**
   Complete Address: 500 S. University Ave., Ste 317, Little Rock, AR 72205
   Phone Number: 501-664-4117 Fax Number: 501-664-1137
3. The specific information to be requested or released is:
   List dates of service: _____
   - ☒ All Medical Records
   - ☐ Clinic Visit Notes
   - ☐ Lab
   - ☐ Physical
   - ☒ Shot Record
   - ☐ Other: _____
4. The information is needed for:
   - ☐ Camp
   - ☐ School/Daycare
   - ☐ Insurance
   - ☒ Continuity of Care
   - ☐ Legal Reasons
   - ☐ Other: _____
5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed and no longer protected by these regulations.
6. I understand that Arkansas Pediatric Clinic will be paid for the costs of copying the information to be released.
7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed under this authorization.
8. I understand that I may revoke this authorization in writing at any time by delivering a copy of my revocation to Arkansas Pediatric Clinic except to the extent that action has been taken in reliance on this authorization. This authorization expires: **One year from date signed.**
9. I understand Arkansas Pediatric Clinic will release the requested information only to the entity listed above.

PLEASE PRESENT A COPY OF A PHOTO ID

_____ _____
Signature of Patient or Representative Date

_____ _____
Phone Number Relationship to Patient