PrimeCARE MEDICAL CLINIC

FOSTER CARE DEMO/HIPAA

Patient Information Record

Today's Date: _____

(This must be COMPLETELY filled out EVERY TIME a child is seen at PrimeCARE)

Patient Name: _____ Intake Date *(if initial)*: _____
First *Middle* *Last*

Date of Birth: _____ SSN: _____ Medicaid #: _____

Sex: ☐ M ☐ F Race: ☐ Asian ☐ Black /African-American ☐ Caucasian ☐ Hispanic ☐ Other

County Responsible for Bill: _____ County Phone #: _____

County Billing Address: _____
Street *Apt #* *City* *State / Zip*

Name of Foster Parent: _____ Foster Parent Phone #: _____
First *Last*

Name of Case Worker: _____ Case Worker Phone #: _____
First *Last*

NOTICE

Please make sure the receptionist gives you a copy of this form to turn in to your county DHS office. For your convenience, the Medicaid number may be written on this form and faxed back to PrimeCare as indicated. Once the ID number has been assigned and Dr. Washington, Dr. Wornock, Dr. Hall or Dr. Lee have been listed as the patient's PCP for this date of service, please fax to the clinic the patient was seen at.

PrimeCare Medical Clinic - Searcy Fax: **501-279-9011**
PrimeCare Medical Clinic - Conway Salem Fax: **501-764-1802**
PrimeCare Medical Clinic - Conway Oak Fax: **501-327-7121**
PrimeCare Medical Clinic - North Little Rock Fax: **501-812-6677**

CONSENT

As a caseworker, foster parent, or other authorized person, it is my responsibility to provide a correct Medicaid ID number for the patient as soon as it is made available.

By signing below, I am stating that I have authorization from the above listed county to bring this child in for treatment and that the county will be responsible for this bill if insurance does not pay.

Print Name: _____ Date: _____
First *Last*

Signature: _____

Patient Authorization:
I authorize PrimeCare Medical Clinic to apply for benefits on my behalf for services rendered. I certify that the information I have reported to PrimeCare with regard to my insurance is correct. I also authorize the release of any necessary information, including medical information if requested by my insurance company. I permit a copy of this authorization to be used in such instances. By signing below, I agree to pay all charges for services rendered by PrimeCare which are not covered by my insurance. If it becomes necessary for PrimeCare to seek judicial action to enforce the above agreement, I agree to pay all collection fees and all attorney's fees of PrimeCare for such action.

Policy Regarding Medical Records and Guardianship:
I recognize that as a recipient of Foster Care, the Arkansas Department of Health and Human Services and its representatives serve as the acting guardian for the related health visits while in active Foster Care. Medical records requests for these visits will be denied if it is not authorized by DHS.

Patient Right to Privacy/Confidentiality:
PrimeCare is committed to patient privacy and confidentiality in compliance with HIPAA. Please complete the following so we can ensure the privacy and confidentiality of your information to the degree required under existing regulations. I authorize PrimeCare Medical Clinic to leave medical information pertaining to my care by the following methods and know that it is my responsibility to update this information should the information change:

Please provide the best contact number to reach you:

_____

Okay to leave message? ☐ Yes ☐ No

Okay to text phone? ☐ Yes ☐ No

List any people authorized to receive your health information with relationship and phone number:

	Name	Relationship	Phone #:
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

I have read and understand the above information:

_____ _____

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

1.	_____	_____	_____
	Doctors first and last name	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) _____

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. This Notice describes the types of uses and disclosures of my protected health information (PHI) that might occur in my treatment, payment of my bills, or in the performance of health care operations. This form will be filed in the patient's medical record.

Please Print the Patient's name _____ Date _____ Please Sign your name _____

Legal Representative or parent's name if patient is a minor _____ Relationship to Patient _____