



Patient Information Record

Today's Date: _____

W/C DEMO/HIPAA

Workers Compensation, Drug Screen, Physical, Injury Date

Patient Name: First Middle Last Date of Birth: _____

Mailing Address: Street Apt # City State / Zip

Home Phone #: Cell Phone #: Sex: M F

SSN: Race: Asian Black /African-American Caucasian Hispanic Other

Emergency Contact: Relationship to Patient:

Emergency Contact Cell Phone #: _____

Employer Name: _____

Employer Contact Person: First Last Employer Contact Phone #: _____

CONTINUE ON NEXT PAGE ->

EMPLOYER INFORMATION OFFICE USE ONLY

Employer Name: _____

Address: Street Apt # City State / Zip

Employer Contact Person: First Last Employer Contact Phone #: _____

Billing Address (if different): Street Apt # City State / Zip

WORKER'S COMPENSATION INSURANCE CARRIER (Complete if employer wants to file with workers' comp insurance)

*WC Insurance Company Name: Phone Number: _____

Claims Mailing Address: Street Apt # City State / Zip

Claim Number: Fax Number: _____

SERVICES (Please CIRCLE the desired option)

- Drug Screen Required: Yes / No - If Required, we offer: In house (12 Panel Rapid DS), Send Out (Quest Lab), DOT or Non DOT, Pre-Employment or Random

- Physical Required: Yes / No - If Required, we offer: DOT or Non DOT, Pulmonary Function Test: Yes / No *Please provide a list of any testing required during the physical examination to meet your employer's requirements. (Labs, Breathing Tests, EKG, X-Ray, TB skin Test, etc.)

OFFICE VERIFICATION OF EMPLOYER INFORMATION Verified By: Employer Representative Contacted:



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 the workers' compensation insurance. 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 workers' compensation policy. 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:

I hereby authorize PrimeCare Medical Clinic to release my medical information as I have directed. I understand that PrimeCare Medical Clinic does not copy records and that such record copying services are subject to a copying charge. I also understand that said records must be requested at least one week in advance of desired receipt date. I understand that the cost for copying/printing medical records is \$ 0.50/page for the first 25 pages and \$0.25 for each additional page. Additionally, a labor charge of \$15.00 may be added for each medical record request. I understand I will be billed by PrimeCare Medical for copying those records. Patients or other parties authorized by the patient to request records for legal issues, insurance, disability (not workman's comp), physician change, or relocation are subject to a copying charge. There will be no charge for copying records for a referral to another physician made by a PrimeCare Medical Clinic provider, or workman's compensation issues or any other situations covered by Arkansas Law.

Telemedicine:

At the recommendation of the PrimeCare medical provider and with my permission, I hereby authorize my consent to receive Telemedicine services at PrimeCare Medical Clinic. I understand that my image and my protected health information will be transmitted electronically through the videoconference platform to authorized PrimeCare medical personnel for the purpose of providing medical diagnostic assessment and treatment services. I understand that I can withdraw this permission at any time prior to the videoconference, of which shall carry no negative impact on my ability to continue care at PrimeCare. I understand that there are limits to Telemedicine technology and there is no guarantee that a Telemedicine session will eliminate the need for me to see a provider in person in order to receive appropriate or additional treatment for my current condition.

Patient Right to Privacy/Confidentiality:

PrimeCare is committed to patient privacy and confidentiality in compliance with HIPAA. I authorize PrimeCare Medical Clinic to leave or collect my 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: SMS/Text messaging, online form submission (Typeform or similar vendor), email messaging.

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:

X: _____

Signature of Patient Parent/Guardian

_____ Date

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

PATIENT ACKNOWLEDGEMENT OF NO SHOW POLICY

A "No Show" is defined as failure to show up to a scheduled appointment. If you are unable to keep your scheduled appointment, you must provide PrimeCARE notice the day prior to the scheduled appointment slot in order to avoid a penalty. No notice, or notice given the day of the scheduled appointment will result in the following actions:

- First Missed Visit: No Charge Issued
- Second Missed Visit: \$50 Charge Issued
- Third or more Missed Visit: Standard Appointment Rate Charge Issued

PrimeCARE does provide appointment reminders through a text messaging system. It is the responsibility of the patient to notify our facility if the phone number on file has changed or can no longer receive messages.

Appeals: Patients wishing to appeal their penalties/charges can present their request and an explanation of their extenuating circumstances by calling our No Show appeals agent at (501) 203-0532.

The undersigned acknowledges the No Show Policy for this healthcare facility. 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