NORTH HILLS FAMILY MEDICAL CENTER
REGISTRATION INFORMATION

Name: _____ Social Security #: _____
Last Name First Name M.I.

Address:_____City:_____State:_____Zip:_____

Age: _____Date of Birth: _____ Home #: _____Cell #: _____

Work #: _____Email: _____

PLEASE CIRCLE

Gender: Male / Female **Marital Status:** Single / Married / Widowed / Separated / Divorced

Race: African American / Asian / Caucasian / Hispanic / Other:_____

Ethnicity: Latino/Hispanic or Other

Do you require assistance for a hearing impairment? (Circle One) Yes / No

Preferred Language: _____ If not English, will you require an interpreter? (Circle One) Yes / No

Emergency Contact: _____
Name Relationship Phone

INSURANCE INFORMATION

Primary Insurance

Carrier:_____ Policy Holder: _____

ID#:_____ Group #: _____

Secondary Insurance

Carrier:_____ Policy Holder: _____

ID#:_____ Group #: _____

Payment is required at time of service unless other arrangements have been made with the office manager. A copy of your insurance card is required if you have coverage.

I request that payment of authorized insurance company benefits be made on my behalf to North Hills Family Medical Center for any services furnished to me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related insurance company claim. If item 9 of the HFCA-1500 claim form is completed, my signature authorizes releases of the information to the insurer or agency shown. In Medicare.other insurance company assigned cases, the physician or other supplier agrees to accept the charge determination of the Medicare/other insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Co-Insurance and deductibles are based upon the charge determination of the insurance company. I agree to pay any amount not covered by my insurance company.

Signature:_____ Date:_____

MEDICAL/HEALTH HISTORY

Patient name:_____ Date of Birth:_____

Past Medical History (please circle all that apply)

Allergies	Circulation Problems	Kidney disease	Skin problems
Anemia	Crohn's/Ulcerative Colitis	Liver disease	Stroke
Anxiety disorder	Depression	Loss of memory/dementia	Thyroid problems
Arthritis	Diabetes	Lung disease	Traumatic injuries
Asthma	Ear or hearing problems	Migraines	Tuberculosis
Atrial fibrillation	Heart attack	Multiple sclerosis	Ulcer/other GI problems
Blood clots	Heart disease	Osteoporosis	Urinary problems
Bipolar disorder	Hepatitis	Parkinson's disease	Valve disease
Cancer	High blood pressure	Seizures/epilepsy	Vision or eye problems
Chest pain	High cholesterol	Other:	

Past Surgical History (Please list all prior surgeries. Includes dates and complications.)

1._____

2._____

3._____

4._____

5._____

Health Maintenance (Approximate dates are fine.)

Immunizations	**Date Received**	**None**	**Not sure**	**Tests**	**When**	**Where**	**None**
Flu				Colonoscopy			
Pneumonia				Mammogram			
Tetanus				Pap			
Shingles				DEXA			
MMR				Prostate			

Medicare patients: When was your last Medicare Wellness?_____

Allergies (Please list name and reaction)

_____

_____

FAMILY HISTORY

Check all that apply. Please also indicate if aunt/uncle/grandparents in the “other” box.

Family member	Mother	Father	Sister(s)	Brother(s)	Other:	
Living?	**Y / N**	**Y / N**	**Y / N**	**Y / N**	**Y / N**	**Relationship**
Diabetes						
Hypertension						
Heart Disease						
Cancer						
Mental Illness						

SOCIAL HISTORY (Please circle all that apply)

Tobacco Use	Nonsmoker	Former smoker	Current smoker	Other (vape, etc):_____
Alcohol Use	None	2-4 times/month	2-3 times/week	Daily or almost daily
Caffeine Use	None	1-2 cups/day	2-3 cups/day	3-4 cups/day
Drug Use	None	Current	Former	Type:_____

MEDICATIONS

List any prescription, herbal or over-the-counter medications that you are currently taking

Medication	Strength	Dosage/Directions	Purpose (what is it treating?)

Do you have a preferred pharmacy? Name:_____ Phone #:_____

I have completed an ADVANCE DIRECTIVE(circle): Yes No If yes, what kind? _____

I would like information regarding ADVANCE DIRECTIVES: Yes No

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

North Hills Family Medical Center
4601 East McCain Blvd.
North Little Rock, AR 72117
Phone: 501-945-4200
Fax: 501-845-0906

Name of Patient:_____ Date of Birth:_____

I hereby request that my Protected Health Information be disclosed to the following person(s) or offices:

Person(s) or office to receive information (name and contact #):

_____ relationship:_____

_____ relationship:_____

_____ relationship:_____

_____ relationship:_____

_____ relationship:_____

Information to be released:

_____

Reason for use and/or disclosure:

_____

Signature of Patient/Legal Representative (if applicable):_____ Date:_____

Print Name of Patient/Legal Representative (if applicable):_____

Relationship to Patient (if applicable):_____

Except to the extent that action has already been taken in reliance upon the authorization, I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at 4601 East McCain Blvd, North Little Rock, AR 72117. Unless revoked, this authorization will expire 12 months from the date of signing or upon (date or event) _____.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, I may inspect or copy any information to be used or disclosed under this authorization.

I understand that, if the person/entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my HPI under other applicable state or federal laws and regulations. I further understand that the person(s) I am authorizing to use or disclose my HPI may receive compensation (either directly or indirectly) for doing so.

YOU ARE ENTITLED TO A COPY OF THIS REQUEST

[North Hills Family Medical Center]

NOTICE OF PRIVACY PRACTICES

Effective Date: October 1, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer: Pennie Biggerstaff
Malling Address: 4601 East McCain Blvd. North Little Rock, AR 72117
Telephone: 501-945-4200
Fax: 501-945-0906
E-mail: nhfmc1@sbcglobal.net

About This Notice: We are required by law to maintain the privacy of Protected Health Information (PHI) and to give you this Notice explaining our privacy practices with regard to that Information. You have certain rights - and we have certain legal obligations - regarding the privacy of your PHI, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information (PHI)?:Protected Health Information (PHI) is Information that individually identifies you and that we create or get from you or from another health care provider, a health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your PHI:We may use and disclose your PHI in the following circumstances: For Treatment. We may use PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel who are involved in taking care of you, including people outside our practice, such as referring or specialist physicians. For Payment. We may use and disclose PHI so that we can bill for the treatment and services you get from us and can collect payment from you, an Insurance company, or another third party. For example, we may need to give your health plan information about your treatment. In order for your health plan to pay for that treatment. We also may tell your health plan about a treatment you are going to receive to find out if your plan will cover the treatment. If a bill is overdue we may need to give PHI to a collection agency to the extent necessary to help collect the bill, and we may disclose an outstanding debt to credit reporting agencies. For Health Care Operations. We may use and disclose PHI for our health care operations. For example, we may use PHI for our general business management activities, for checking on the performance of our staff in caring for you, for our cost-management activities, for audits, or to get legal services. We may give PHI to other health care entities for their health care operations, for example, to your health insurer for its quality review purposes. Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you. Minors. We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law. Personal Representative. If you have a personal representative, such as a legal guardian (or an executor or administrator of your estate after your death), we will treat that person as if that person is with respect to disclosures of your PHI. As Required by Law. We will disclose PHI about you when required to do so by international, federal, state, or local law. To Avert a Serious Threat to Health or Safety. We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat. Business Associates. We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy of your PHI. Organ and Tissue Donation. If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation such as an organ donation bank - as necessary to facilitate organ or tissue donation and transplantation. Military and Veterans. If you are a member of the armed forces, we may release PHI as required by military command authorities. We also may release PHI to the appropriate foreign military authority if you are a member of a foreign military. Workers' Compensation. We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness. Public Health Risks. We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (8) the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure. Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves if you sue us. Law Enforcement. We may release PHI if asked by a law enforcement official for the following reasons: In response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime. National Security. We may release PHI to authorized federal officials for national security activities authorized by law. For example, we may disclose PHI to those officials so they may protect the President. Coroners, Medical Examiners, and Funeral Directors. We may release PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties. Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional Institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

Individuals Involved In Your Care or Payment for Your Care. We may disclose PHI to a person who is involved in your medical care or helps pay for your care, such as a family member or friend, to the extent it is relevant to that person's involvement in your care or payment related to your care. We will provide you with an opportunity to object to and opt out of such a disclosure whenever we practicably can do so. Disaster Relief. We may disclose your PHI to disaster if organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with the opportunity to agree or object to such a disclosure whenever we practically can do so.

Prior Written Authorization is Required for Other Uses and Disclosures: Uses and disclosures for marketing purposes and disclosures that constitute a sale of PHI can only be made with your written authorization. Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. Disclosures that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

NORTH HILLS FAMILY MEDICAL CENTER

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____ have received a copy of North Hills Family Medical Center's
(Print Patient's name)
Notice of Privacy Practices.

_____ _____ _____
Signature of Patient Date of Birth Date

DISCRIMINATION IS AGAINST THE LAW

North Hills Family Medical Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

North Hills Family Medical Center provides free aids and services to people with disabilities to communicate effectively with us, such as:

- **Qualified sign language interpreters**
- **Written information in other formats (large print, audio, accessible electronic formats, other formats)**

North Hills Family Medical Center provides free language services to people whose primary language is not English, such as:

- **Qualified interpreters**
- **Information written in other languages**

You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- **Electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**
- **By mail at**
  U.S. Department of Health and Human Services
  200 Independence Ave SW
  Room 509F HHH Building
  Washington, DC 20291
- **By phone at 1-800-368-1019; 800-537-7697 (TDD)**

Complaint forms are available at http://www/hhs.gov/ocr/office/file/index.html

GAD-7

Over the **last two weeks**, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3
Totals				

Total Score:_____

PHQ-9

Over the **last two weeks**, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Totals				

Total score:_____

ASQ

1. In the past few weeks, have you felt that you or your family would be better off if you were dead?	Yes	No
2. In the past week, have you been having thoughts about killing yourself?	Yes	No

OFFICE USE ONLY

DIAGNOSIS: Y / N IF NO, ACTION NEEDED: ES / PROVIDER

HPI> SMARTFORM> DEPRESSION> INTERVENTION> FINDINGS> FOLLOW-UP

AUDIT-C Questionnaire

Patient Name_____ Date_____

One drink equals:

12 oz. beer

5 oz. wine

1.5 oz. liquor (one shot)

1. Did you have a drink containing alcohol in the past year?
   - ☐ Yes
   - ☐ No (Stop here)

2. How often do you have a drink containing alcohol?
   - ☐ Never
   - ☐ Monthly or less
   - ☐ 2-4 times a month
   - ☐ 2-3 times a week
   - ☐ Daily or almost daily

3. How many drinks did you have on a typical day when you were drinking in the past year?
   - ☐ 1 or 2 drinks
   - ☐ 3 or 4 drinks
   - ☐ 5 or 6 drinks
   - ☐ 7 to 9 drinks
   - ☐ 10 or more drinks

4. How often did you have six or more drinks on one occasion in the past year?
   - ☐ Never
   - ☐ Less than monthly
   - ☐ 2 to 4 times a month
   - ☐ 2 to 3 times per week
   - ☐ 4 or more times a week