APC POLICIES & PROCEDURES

APPOINTMENTS

- We will try our best to accommodate your schedule, but we can't guarantee that the time we can work you in will be your first choice. We must offer appointment slots on a first-come, first-serve basis.
- Parents must bring their child's insurance card to each and every visit.
- ***HIPAA RELEASE FORMS MUST BE FILLED OUT PER CHILD AND MUST BE COMPLETED BY PARENTS/LEGAL GUARDIANS*** granting others permission to bring child to appointments/place nurse call/schedule appointments, etc. ***IF THIS FORM IS NOT FILLED OUT CHILD WILL NOT BE SEEN AND WILL HAVE TO RESCHEDULE APPOINTMENT.***
- ***PAYMENT IS DUE AT TIME OF SERVICE.***
- A fee of $25 will be charged to child's account if any appointment is missed or not cancelled before the appointment time. ***THIS FEE MUST BE PAID BEFORE ANY OTHER APPOINTMENTS CAN BE MADE FOR THE PATIENT AND SIBLINGS.***
- Arriving more than 15 minutes late for a Well Child exam/ADD/ADHD or other non-urgent appointments will be required to reschedule and will be charged a missed appointment fee.
- Arriving more than 30 minutes late for a Sick/Office Visit will be required to reschedule and will be charged a missed appointment fee.
- Any patient under the age of 18 ***MUST BE*** accompanied by a parent/legal guardian or other authorized person.
- ***IT IS PARENT/LEGAL GUARDIAN'S RESPONSIBILTY TO MAKE SURE THAT WE HAVE CURRENT DEMOGRAPHIC INFORMATION UP TO DATE*** (address, phone numbers, etc.).

PAPERWORK/MEDICAL RECORDS

- Parents/legal guardians must call in advance for paperwork to be filled out.
- Forms for Camp, Sports, etc. will only be completed by the provider if the child has had a Well Child exam within the past year and documentation is on file.
- ***SHOT RECORDS MUST BE ORDERD IN ADVANCE THROUGH A NURSE CALL.***
- Medical records must be requested in person and will be printed at that time.
- Paperwork/Medical records must be picked up by parents/legal guardians unless HIPAA forms have been completed and is in that patient's chart.
- Paperwork will be completed on a first-come first-serve basis *and* ***WILL BE COMPLETED AT THE PROVIDER'S DISCRETION.***

ADD/ADHD APPOINTMENTS/REFILLS

- ***MEDICATION REFILL REQUESTS MUST BE SUBMITTED TWO WEEKS IN ADVANCE.***
- All ADD/ADHD/Behavioral Concerns must be rechecked every three to six months depending on the provider. These appointments must be scheduled at least ***ONE MONTH*** in advance to prevent running out of medication.
- New ADD/ADHD/Behavioral Concerns must be approved through the Nurses/Providers first and may be referred out to other offices.
- Only parents/legal guardians are able to pick up prescriptions for controlled substances unless proper authorizations are on file. Also, no one under the age of 18 may pick up these prescriptions.

BALANCES

- ***ALL PAYMENTS ARE DUE AT TIME OF SERVICE.***
- For existing balances, we ask that you pay at least $25 each month.
- If your account goes over ***NINETY DAYS WITHOUT PAYMENT***, it will be turned over to ***COLLECTIONS, NO EXCEPTIONS***.
- Once an account is turned over to collections, payment must be made to the collection agency or balance can be paid in full at our office.

Arkansas Pediatrics of Conway

P.O. BOX 1210 • CONWAY, AR 72033 • (501) 329-1800
FAX: (501) 329-2507 • arkansaspediatrics@conwaycorp.net

Patient Information

Child's Name_____ _____
Last Name First Name Middle Name DOB

Sex_____ Age_____ SSN_____ Nickname_____ Race_____

Mailing Address_____
Street/Apt City State Zip

Legal Guardian(s)_____Primary Phone_____ Secondary Phone_____

Sibling(s) seen in our office_____ Who referred you? _____

Parent Information

Father's Name_____

Address_____

_____

Phone_____

Occupation_____

SSN_____ DOB_____

Does this person carry insurance for this child? Y__ N__

Plan Name_____

ID#_____

Group#_____

Is your child covered by Medicaid? Y__ N__

Mother's Name_____

Address_____

_____

Phone_____

Occupation_____

SSN_____ DOB_____

Does this person carry insurance for this child? Y__ N__

Plan Name_____

ID#_____

Group#_____

Child's Medicaid #_____

Emergency Contact (someone other than parents):
Name_____Relationship_____ Phone#_____

I, the undersigned, assign directly to Arkansas Pediatrics of Conway all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____
Signature of Parent/Legal Guardian Date

Steven D. McNabb, M.D., F.A.A.P. R. Alan Lucas, M.D., F.A.A.P. Philip Hopp, M.D., F.A.A.P.
Deborah Jackson, A.P.R.N. Karen Baker, M.D., F.A.A.P. Megan Osam, A.P.R.N.
Karen Martin, A.P.R.N. Betsy Efird, A.P.R.N.

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New Patient Questionnaire

Patient Name_____ DOB_____ Date_____

PAST MEDICAL HISTORY

Does your child ***have*** or ***have they been treated for*** any of the following (check all that apply)?

___ AIDS/HIV
___ Allergies
___ Asthma
___ Reflux
___ Noisy breathing
___Sleep apnea
___ Hearing loss
___ Sickle cell anemia
___ Tuberculosis (TB)
___ Seizures
___ Heart disease
___ Lung disease
___ Kidney disease
___ Meningitis
___ Chicken pox or Shingles
___ Bleeding disorder
___ Frequent ear infections
___Cancer (type: _____)
___ Transplant (type: _____)
___ Other: _____

HOSPITALIZATIONS (Please list)

DATE REASON

_____ _____

_____ _____

SURGERIES (Please list)

DATE REASON

_____ _____

_____ _____

CURRENT MEDICATIONS (including vitamins, herbs, and over-the-counter)

NAME DOSE NAME DOSE

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Does your child have any **ALLERGIES TO MEDICATIONS?** ___ Yes ___ No
If yes, please list the medicine and described the reaction:

_____

_____

FAMILY HISTORY (Please check all that applies to child's family members & list who has that illness)

___ Allergy _____ ___ Asthma _____ ___ Cystic fibrosis _____
___ Ear infections _____ ___ Hearing loss/deafness _____ ___ Bleeding disorder _____
___ Thyroid disease _____ ___ Problem with anesthesia _____ ___ Cancer (type:_____) _____

SOCIAL HISTORY

Are your child's **IMMUNIZATIONS** up to date? ___ Yes ___ No
Were **ALL** immunizations done in the state of Arkansas? ___ Yes ___ No
Is your child currently in daycare? ___ Yes ___ No
Is your child exposed to tobacco smoke? ___ Yes ___ No
Is there concern for suspected abuse, physical assault, sexual molestation/rape, domestic violence, unsafe living situation, substance abuse or caregiver with psychiatric diagnosis in the home? ___ Yes ___ No

BIRTH HISTORY

Was your child born prematurely? ___ Yes ___ No
If yes, by how many weeks? _____
Was NICU stay required? ___ Yes ___ No
What was your child's birth weight? _____
Has your child ever needed a breathing tube or ventilator? ___ Yes ___ No
Did your child pass their newborn hearing screening test? ___ Yes ___ No
Did your child have any problems at the time of delivery? ___ Yes ___ No

HIPAA GENERAL CONSENT

I hereby give my consent for Arkansas Pediatrics of Conway to use or disclose my Protected Health Information to carry out treatment, payment, or any other health care operations. I understand that my Protected Health Information is as follows:

Information that is oral or recorded in any form that relates to my past, present, or future, physical or mental health condition, my past, present, or future health care treatment, or the payment of my past, present, or future health care treatment, that is or could reasonably identify me and is transmitted in an electronic form or maintained in any form.

This Protected Health Information could include information that this Health Care Provider created, received from me, received from another Health Care Provider, received from a Health Plan, Health Care Clearing House, Insurance Company, Employer, or any other source, and could include demographic information about me.

I have been informed that my Health Care Provider has adopted a complete statement of its privacy practices, which are contained in Arkansas Pediatrics of Conway Notice of Privacy Practices. I have received a copy of the Notice of Privacy Practices and have had an opportunity to review them and ask any questions concerning them before signing this HIPAA Consent. I understand that my Health Care Provider has the right to change them at any time without advance notice to me. I can request a copy of my Health Care Provider's latest Notice of Privacy Practices by calling the office, stopping by and picking up a copy, stopping by and reading the Notice that is posted in my Health Care Provider's waiting room, or asking that my name be put on a list to be mailed a copy of any updated Notice of Privacy Practices should my Health Care Provide make changes to the Notice of Privacy Practices.

I understand that I have the right to not give this consent; however, I also understand that my Health Care Provider does not have to treat me if I do not sign this consent.

I understand that I have the right to request restrictions on this consent and to request limits on when and how my Health Care Provider uses and discloses my Protected Health Information, however, I understand my Health Care Provider is not obligated to agree to the restrictions or limitations I request.

I understand that if my Health Care Provider agrees to a restriction, my Health Care Provider shall be bound by the restriction until I release my Health Care Provider from that restriction.

I understand that I have the right to revoke my consent; however, it shall not be considered revoked to the extent my Health Care Provider has relied on it.

I hereby consent to all the uses and disclosures in my Health Care Provider's Notice of Privacy Practices.

_____ _____

Patient – Printed Name Patient – Signature (18 years and older)

_____

Date

_____

Parent/Guardian Signature (under 18 years old)

Arkansas Pediatrics of Conway

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Appointment Policy

We appreciate the opportunity to provide your child's healthcare. Recently we have experienced an increase in patients missing their appointments as well as being late for their appointments. Effective May 1, 2008, we have instituted the following appointment policy.

To ensure time for addressing your concerns, **all patients are seen by appointment only**. Because we know your time is valuable, we try to adhere to the appointment schedule as closely as possible. On occasion, waiting time may lengthened by unforeseeable circumstances. We appreciate your patience in these situations.

When making your child's appointment, tell the receptionist the reason for your visit and any information that will help us schedule the proper time for your appointment. If you have more than one child needing to be checked, please let the receptionist know when you call so a separate appointment can be made. In consideration of all patients and to adhere to our schedule, we cannot address multiple issues (or children) in a single visit time slot.

Same Day Appointments

We offer same day sick appointments for established patients. We ask that you call as early in the day as possible to make an appointment. For most acute illnesses, you will be offered the first available appointment of that day. We will try to accommodate your schedule, however we cannot guarantee the appointment time will be your first choice.

On those days when all appointment slots are filled, your call will be forwarded to the nurse who will return your call as soon as possible. She will assess your child's need for a same day appointment that may be worked in, or else schedule an appointment for the following day. We understand your concern when your child is sick and will make every effort to see them as quickly as possible.

Missed/Late Appointments

Missed appointments represent a cost to the clinic, to you, and to the other patients who could have been seen in the time allotted for your visit. We understand unforeseen circumstances can arise after appointments have been made. All appointment cancellations should be made at least 24 hours in advance so another patient can be scheduled in that slot.

MISSED APPOINTMENTS WILL BE CHARGED A $25 FEE WHICH MUST BE PAID BEFORE YOUR NEXT VISIT FOR THAT CHILD AND/OR ANY OTHER CHILD. ONCE YOU HAVE MISSED TWO APPOINTMNETS WITHOUT ADAQUATE NOTICE TO THE CLINIC, APC WILL NO LONGER PROVIDE HEALTHCARE FOR YOUR CHILD. We will provide emergency coverage for one month while you find another healthcare provider. Missed double appointments (with two children) will be restricted from scheduling double appointments in the future and be responsible for the missed appointment fee per patient.

Arriving late for your child's appointment also extends the waiting time for the other patients. If you are going to be late please call prior to your appointment time to reschedule. In fairness to all patients, those sick patients arriving more than 15 minutes after their appointment time will be worked in between other patients that arrived on time. Please understand if you arrive late this may cause an extended waiting time before your child can be seen. **SICK PATIENTS ARRIVING MORE THAN 30 MINUTES AFTER THEIR APPOINTMENT WILL HAVE TO RESCHEDULE AND WILL BE CHARGES A $25 MISSED APPOINTMENT FEE**.

For Well Child Exams we encourage you to arrive 10-15 minutes early to allow time for weighing and measuring of your child. **ARRIVING MORE THAN 15 MINUTES LATE FOR YOUR CHILD'S WELL CHILD EXAM OR OTHER NON-URGENT RELATED VISITS (i.e. ADD/ADHD VISITS) WILL BE REQUIRED TO RESCHEDULE AND WILL BE CHARGED A $25 MISSED APPOINTMENT FEE**.

I acknowledge that I have received a copy of the Appointment Policy of Arkansas Pediatrics of Conway. I understand I may be responsible for a $25 Missed Appointment Fee should I fail to comply with the policy guidelines.

_____	_____	_____
Patient Name-Printed	Parent/Guardian Signature	Date

Steven D. McNabb, M.D., F.A.A.P. — R. Alan Lucas, M.D., F.A.A.P. — Philip Hopp, M.D., F.A.A.P.
Deborah Jackson, A.P.R.N. — Karen Baker, M.D., F.A.A.P. — Megan Osam, A.P.R.N.
Karen Martin, A.P.R.N. — Betsy Efird, A.P.R.N.

Arkansas Pediatrics of Conway
2710 College Ave.
Conway, AR 72034
Phone: (501)329-1800

Arkansas Pediatrics of Conway
Patient Insurance Waiver

I understand the following regarding my insurance:

- **Your health insurance contract is between you and your insurance company. Knowing your benefits is your responsibility. Any questions or complaints regarding your coverage should be directed to your insurance company.**

- **Insurance card must be presented before services are rendered. If you have forgotten your card we will be happy to assist you in rescheduling to another day.**

- **Due to time constraints, we are unable to investigate which insurance company you have.**

- **Due to different procedures for processing accounts, we cannot change the form of payment to insurance at a later date. If you are using insurance, you must notify our staff at the time of service and present your insurance card that day.**

_____ _____
Patient Name and DOB **Date**

_____
Parent or Guardian Signature

_____
Please Print Parent or Guardian Name

SPECIFIC AUTHORIZATION

I hereby give my authorization for Arkansas Pediatrics of Conway to use or disclose my Protected Health Information to carry out treatment, payment, or any other health care operations.

I understand that my Protected Health Information is as follows:

> *Information that is oral or recorded in any form that relates to my past, present, or future, physical or mental health condition, my past, present, or future health care treatment, or the payment of my past, present, or future health care treatment, that is or could reasonably identify me and is transmitted in an electronic form or maintained in any form*.

This Protected Health Information could include information that this Health Care Provider created, received from me, received from another Health Care Provider, received from a Health Plan, Health Care Clearing House, Insurance Company, Employer, or any other source, and could include demographic information about me.

I specifically give this Health Care Provider authorization to use or disclose my Protected Health Information to the following persons for the following purposes:

Name	Address	Phone Number	Purpose

I understand that I have the right to revoke my authorization; however, it shall not be considered revoked to the extent my Health Care Provider has relied on it. I understand that once this information has been disclosed to third parties, there may not be any safeguards to prevent the third party from further disclosing the Protected Health Information.

I request this authorization expire on the following date: _____,20_____ or **I request that this authorization expire when the child reaches the age of majority**. I may revoke it sooner in writing by contacting the Privacy Official Donna Strickland, I may also reach her by phone at 501-329-1800. I understand the Health Care Provider cannot condition my treatment or evaluation on my signing this authorization.

_____ _____

Patient – Printed Name Patient – Signature (if age 18 or older)

_____

Patient's Date of Birth

_____ _____

Parent/Guardian of Patient Today's Date

Arkansas Pediatrics of Conway

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FAX: (501) 329-2507 • dstrickland@arkansaspediatrics.com

Patient Portal Consent Form

The patient portal is a secure web portal that allows you as a patient to access medical information online, so you can view your personal health record whenever and wherever you have access to the internet. It also allows you to communicate with our office via secure messaging. You may request refills and ask a nurse a question.

Please read the following policy carefully:

- We are offering the patient portal as a convenience to you at no cost. We do not sell or give away any private information, including email addresses, without your written consent. We reserve the right to suspend or terminate the patient portal at any time and for any reason.
- We will make every attempt to return portal messages within one business day. You must call our office at 501-329-1800 if you have an urgent matter to discuss. Please do NOT use the portal for emergencies.
- We do NOT refill controlled substances over the portal.
- If you are not receiving emails from us, please check your JUNK email folder before contacting our office.
- By using this patient portal, you agree to protect your password from any unauthorized individuals. It is your responsibility to notify us should your password be stolen. You agree to not hold Arkansas Pediatrics of Conway responsible for any network infractions beyond our control.

Your Email Address_____

Patients Name_____ Date of Birth_____
(Please Print)

Guardian Signature_____ Date_____

Steven D. McNabb, M.D., F.A.A.P.
Deborah Thornhill, A.P.N.
Karen Martin, A.P.N.
R. Alan Lucas, M.D., F.A.A.P.
Karen Baker, M.D. F.A.A.P.
Philip Hopp, M.D., F.A.A.P.
Megan Osam, A.P.N.
Betsy Efird, A.P.N.

PCP FORM

ARKANSAS MEDICAID PRIMARY CARE PHYSICIAN MANAGED CARE PROGRAM

PRIMARY CARE PHYSICIAN SELECTION AND CHANGE FORM

SELECTIONS:

I HAVE PICKED THE THRE (3) PHYSICIANS NAMED BELOW IN ORDER OF MY PREFERENCE TO BE MY PRIMARY CARE PHYSICIAN (PCP). I UNDERSTAND THAT ONLY ONE (1) OF THEM WILL BE MY PRIMARY CARE PHYSICIAN.

1. _____
   PHYSICIAN NAME
2. _____
   PHYSICIAN NAME
3. _____
   PHYSICIAN NAME

CHANGES:

I WANT TO CHANGE MY PRIMARY PHYSICIAN BECAUSE:

_____
_____
_____
_____
_____
_____
_____

_____ _____
PATIENT'S NAME/DOB **PARENT/GUARDIAN SIGNATURE**

_____ _____
MEDICAID RECIPIENT I.D. # **DATE**