PATIENT REGISTRATION FORM

*Today's date:*_____ *King Medical Clinic*

PATIENT INFORMATION (PLEASE USE FULL LEGAL NAMES, NO NICKNAMES PLEASE)

Last Name:_____ **First Name:** _____ **Middle Int:**____

Password for HIPPA purposes/account access:_____ **Sex:** M F

SSN:_____ **Marital Status:** _____ **Date of Birth:**_____

Race: ☐American Indian/Alaskan Native ☐Asian/Pacific Islander ☐Black/African American ☐White ☐Native American/Pacific Islander ☐Other ☐Declined

Ethnic Group: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined

Address: _____ **Zip:**_____ **City:**_____ **State:**_____

Home Phone:_____ **Cell Phone:** _____ **Work Phone:**_____

Email:_____

Preferred Contact Method: ☐Phone ☐Email ☐Patient Portal

Preferred Reminder Method: ☐Cell Phone ☐Home Phone ☐Office Phone ☐Email ☐Patient Portal

Employer:_____ **Employer Phone Number:** _____

GUARANTOR/PARENT INFORMATION (IF PATIENT IS A MINOR)-----PLEASE USE FULL LEGAL NAMES

Mother's Last Name: _____ **First Name:** _____ **Middle Int:**_____

Date of Birth: _____ **SSN:** _____ **Marital Status:**_____

Home Phone:_____ **Office Phone:** _____ **Cell Phone:**_____

Address (if different from above)_____

Employer Name:_____ **Address:**_____ **Phone:** _____

Father's Last Name: _____ **First Name:** _____ **Middle Int:**____

Date of Birth: _____ **SSN:** _____ **Marital Status:** _____

Home Phone: _____ **Office Phone:**_____ **Cell Phone:**_____

Address (if different from above) _____

Employer Name:_____ **Address:**_____ **Phone:** _____

PRIMARY INSURANCE INFORMATION

Insurance Name: _____ Policy Holder's Name: _____

Policy Holder's SSN: _____ Policy Holder's D.O.B. _____

Member ID# _____ Group # _____ Effective Date: _____

SECONDARY INSURANCE INFORMATION

Insurance Name: _____ Policy Holder's Name: _____

Policy Holder's SSN: _____ Policy Holder's D.O.B: _____

Member ID# _____ Group# _____ Effective Date: _____

EMERGENCY CONTACT LIVING WITH PATIENT

Last Name: _____ First Name: _____

Address: _____

Emergency Phone: _____ Cell Phone: _____ Work Phone: _____

Relationship: _____

EMERGENCY CONTACT NOT LIVING WITH PATIENT

Last Name: _____ First Name: _____

Address: _____

Emergency Phone: _____ Cell Phone: _____ Work Phone: _____

Relationship: _____

PHARMACY: _____

PLEASE PROVIDE NAMES OF IMMEDIATE FAMILY MEMBERS THAT ARE ASSOCIATED WITH THIS ACCOUNT

KING MEDICAL CLINIC
DISCLOSURES & CONSENTS

Patient Name: **Date of Birth:**

PLEASE INITIAL THE FOLLOWING

_____ **ASSIGNMENT OF INSURANCE BENEFITS**

I hereby authorize direct payment of my insurance benefits to King Medical Clinic, or the physician individually for services rendered to me or my dependents by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are covered benefits. I understand, and agree, that I will be responsible for any co-pay or balance due, that King Medical Clinic is unable to collect from my insurance carrier for whatever reasons.

_____ **MEDICARE/MEDICAID/CHAMPUS/OTHER COMMERCIAL INSURANCE BENEFITS**

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my, or my dependent's, benefits be made directly to King Medical Clinic or the physician on my behalf.

_____ **HIPAA / AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION**

I certify that I have received, and read, a copy of King Medical Clinic's HIPAA policy. I hereby authorize King Medical Clinic, or the physician individually, to release any of my, or my dependent's, medical or incidental non-public person information that may be necessary for medical evaluation, treatment, consultations, or the processing of insurance benefits.

_____ **AUTHORIZATION TO MAIL, CALL, E-MAIL OR USE PATIENT PORTAL**

I certify that I understand the privacy risks of the mail, phone calls and e-mail. I hereby authorize a King Medical Clinic representative, or my physician, to use patient portal (if enrolled), mail, call or e-mail me with communications regarding my healthcare, including but not limited to, such things as appointment reminders, referral arrangements and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying King Medical Clinic to that effect in writing.

_____ **LAB/X-RAY/DIAGNOSTIC SERVICES**

I understand that I may receive a separate bill if my medical care includes lab, x-ray or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

_____ **MISSION STATEMENT**

I certify that I have received, and read, a copy of King Medical Clinic's mission statement; which includes general guidelines for office procedures and policies.

_____ **MEDICARE**

I understand that if Medicare becomes my primary insurance, KMC will no longer be able to serve me and my medical needs.

_____ **PAIN MANAGEMENT**

I understand that it is the policy of King Medical Clinic NOT to engage in the practice of managing chronic pain conditions or the medications that may be given for such conditions. Any patient with chronic pain, that does not have a pain management specialist, will be referred to said specialist for management of their chronic condition(s). If the patient refuses to be managed by such specialist, dismissal from the clinic will ensue.

_____ **MISSED/TARDY APPOINTMENTS**

I understand that if I fail to cancel my (or my dependents) appointments within 24 hours prior to my scheduled appointment time that my account may be charged a fee of $ 40.00. I also understand that if I am late for my appointment I may have to be rescheduled. Three (3) no show appointments will result in dismissal from clinic.

_____ **DISABILITY/MVA**

I understand that it is ***NOT*** the policy of King Medical Clinic to participate in any Disability or MVA appointments, claims, paperwork, etc..

_____ **SPLIT BILLING**

I understand that KMC cannot "split bill" invoices or statements, therefore the balance on the account will be liable by the guarantor listed. It is the responsibility of the parents to split/collect any balance due by the other party

_____ **MEDICATION REFILLS**

It is the policy of King Medical Clinic to allow 48 hrs for all prescription refills

_____ **DESTRUCTION OF PROPERTY**

I understand that if any clinic property is damaged or broken, by my dependent or myself, I will be responsible for paying for such damages.

PATIENT NAME: _____ **DATE** _____
(PLEASE PRINT)

GUARANTOR NAME: _____ **DATE** _____
(PLEASE PRINT)

PATIENT OR GUARANTOR SIGNATURE: _____

KING MEDICAL CLINIC

CONSENT FOR RELEASE OF MEDICATION INFORMATION

I hereby authorize the release of medication information to King Medical Clinic as stated below:

Please check ***ONLY ONE*** of the following:

_____ I authorize the release of ***ALL*** medication information, past and present, to King Medical Clinic.

_____ As Parent/Guardian of said minor, I authorize the release of ***ALL*** medication information, past and present, to King Medical Clinic.

_____ Restricted Consent. I authorize release of medication information as prescribed by King Medical Clinic ***ONLY.*** I do not authorize access to any medication prescribed by any physicians other than those at King Medical Clinic.

PATIENT NAME:_____DATE_____
(PLEASE PRINT)

GUARANTOR NAME:_____DATE_____
(PLEASE PRINT)

PATIENT/GUARDIAN SIGNATURE:_____DATE_____

Rachel King MD has joined SHARE, which is Arkansas's statewide health exchange network for Arkansas caregivers to exchange medical information by computer. This helps your doctors coordinate and communicate about your care. Health records today are exchanged by fax machine and mail when needed for your care. SHARE makes it faster and more secure for your providers to electronically exchange your medical records.

What health information will be shared?

Lab and X-ray results, diagnoses, drug allergies, prescriptions, immunization history; medical records that are faxed or mailed can also be sent through SHARE. Sensitive information will not be included, such as adoption, mental health and substance abuse treatment records.

Who can access my information?

Only health care providers participating in SHARE will access your information if they are treating you as a patient, coordinating care, and public health reporting. You can view participating providers at: sharearkansas.com/directory.

How is my privacy protected?

Information exchanged through SHARE is protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). HIPAA regulates the use of your personal health information and requires that your information be protected

With your permission, providers who care for you or your family can get this information through SHARE (the Arkansas State Health Alliance for Records Exchange). Your health information will be made available to your participating health care providers unless you OPT-OUT. If you choose to opt-out, ask your registration clerk for and complete an Opt-Out Form.

☐ Yes. I agree you may transmit and receive my health information by SHARE along with faxing and mailing.

OR

☐ Request to Opt-Out. I choose to opt-out. I do not want my authorized health care providers to access my health information by making an electronic inquiry through SHARE

PRINT PATIENT NAME

First **Middle** **Last**

NAME of LEGAL REPRESENTATIVE/GUARDIAN

Print First and Last Name **Signature**

RELATIONSHIP TO PATIENT

King Medical Clinic

Vaccine Policy Statement

King Medical Clinic strives to provide comprehensive, compassionate and top quality healthcare to all of our patients and families. One of the most important services we can provide our patients is vaccination against life threatening diseases. We strongly agree with the American Academy of Pediatrics (AAP) and Centers for Disease Control (CDC) that childhood vaccines are critical to maintaining healthy children and communities. As medical professionals, we feel that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults.

Our policy is that:

- We adhere to the AAP immunization guidelines that are available at http://www2.aap.org/immunixation/izschedule.html. You may also ask anyone in our office for a copy of the AAP immunization schedule.
- Children must receive all ***routine*** vaccines recommended by the AAP that are mandated for school entry by the Stats of Arkansas, Texas, Louisiana and Oklahoma. ***Seasonal flu and Covid 19 vaccines are ***excluded*** from this policy because they are not considered ***routine***
- Children must begin receiving their immunizations by the age of 2 months.
- We do not follow "alternative" vaccine schedules. Any parents who refuse to adhere to the AAP recommended vaccine schedule, without medical reason, may be discharged from our practice following a 30 day written notice from King Medical Clinic.

Our providers welcome discussion about our vaccine policy with any of our families. We hope you understand we have created this vaccine policy to protect children, their families and our communities form deadly, preventable disease by administering safe and effective vaccines.

We encourage you to discuss any concerns, doubts or questions you may have about vaccines with your healthcare provider.

Parent/Guardian:_____Date:_____
(Please print)

Parent/Guardian: _____Date:_____
(Signature)

King
MEDICAL CLINIC
180 Hwy 71 S.
Ashdown, AR 71822
Phone: (870) 898-5464

I understand the wellness and no show policies of King Medical Clinic, and herby agree to stay in compliance with these said policies and all other policies of the clinic.

I also understand that if I do not stay in compliance with these policies I will risk being dismissed from clinic.

_____ _____

Signature Date