

**Arkansas Psychiatric Clinic (APC) – Patient Information - Minors**

<b>Patient Name:</b>	<b>Date of Birth:</b>	<b>Sex:</b>
<b>Social Security No:</b>	<b>Marital Status:</b>	<b>Religion:</b>
<b>Language:</b>	<b>Ethnicity:</b> Non-Hispanic    Hispanic    Unknown	
<b>Address:</b>	<b>City:</b>	<b>State:</b> <b>Zip:</b>
<b>Phone:</b>	<b>Email:</b>	
<b>Referring Physician:</b>	<b>Primary Doctor (if different):</b>	
<b>Employer:</b>	<b>How did you hear about us?</b>	
<b>Guarantor Information (Person/Entity financially responsible for the patient)</b>		
<b>Name:</b>	<b>Relationship:</b>	<b>Date of Birth:</b>
<b>Social Security No:</b>	<b>Phone:</b>	
<b>Address:</b>	<b>City:</b>	<b>State:</b> <b>Zip:</b>
<b>Employer:</b>		
<b>Spouse Information</b>		
<b>Name:</b>	<b>Date of Birth:</b>	
<b>Social Sec No:</b>	<b>Phone:</b>	
<b>Employer:</b>		
<b>Emergency Contact</b>		
<b>Name:</b>	<b>Relationship:</b>	<b>Phone:</b>
<b>Insurance Information – WE WILL NEED A COPY OF YOUR INSURANCE CARD(S) AND PHOTO ID</b>		
<b>Primary Ins:</b>	<b>Secondary Ins:</b>	
<b>ID:</b> <b>Group No:</b>	<b>ID:</b> <b>Group No:</b>	
<b>Claims Address:</b>	<b>Claims Address:</b>	
<b>City:</b> <b>State:</b> <b>Zip:</b>	<b>City:</b> <b>State:</b> <b>Zip:</b>	
<b>Subscriber Name:</b>	<b>Subscriber Name:</b>	
<b>Relationship to pt:</b>	<b>Relationship to pt:</b>	
<b>Subscriber Soc Sec No:</b>	<b>Subscriber Soc Sec No:</b>	
<b>Subscriber Date of Birth:</b>	<b>Subscriber Date of Birth:</b>	
<b>Subscriber Employer:</b>	<b>Subscriber Employer:</b>	

**Authorization, Consent, and Acknowledgement**

I hereby authorize my insurance benefits to be paid directly to APC. I consent to the use or disclosure of my protected health information by APC for the purpose of diagnosing or providing to me, obtaining payment for my healthcare bills or to conduct healthcare operations of APC> I have the right to revoke this consent in writing at any time, except to the extent that APC has taken action in reliance of this consent. The Notice of Privacy Practices for APC has been provided to me.

\_\_\_\_\_

**Signature of Patient or Guardian**

\_\_\_\_\_

**Date**

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

To Our Patient: the physicians and staff of Arkansas Psychiatric Clinic are committed to the protection of your health information. The Health Insurance Portability and Accountability Act requires that we provide notice to each of our patients of how this information is used. We safeguard information about your health and your person (Protected Health Information, PHI.) We collect information from you and keep it in a designated record set that contains your health and billing information.

## 1. USES AND DISCLOSURES AND PROTECTED HEALTH INFORMATION

Treatment: We will use and disclose your health information to provide, coordinate, and/or manage your healthcare and any related service. For example:

- Sending your appointment reminder
- Obtaining your medical treatment and history and recording it in your chart
- Discussing your care with another healthcare provider

Payment: Your protected health information will be used and disclosed as necessary to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for your services such as determining eligibility and coverage and utilization review.

Healthcare Operations: We may use or disclose, as necessary, your protected health information in order to support standard business activities. We will share your protected health information with third party business associates that perform various activities for Arkansas Psychiatric Clinic. Whenever an arrangement such as this involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect your privacy. For example:

- A contract exists between us and the companies that do our medical transcription.
- A contract exists between us and the collection agency that handles our past due accounts.

## 2. OTHER USES AND DISCLOSURES BASED UPON YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke your authorization at any time in writing. There may be cases where your protected health information has already been released prior to the revocation of the authorization.

Emergencies: We may use or disclose your protected health information in an emergency situation.

## 3. USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include, but are not limited to:

- **Required by Law:** We will disclose your protected health information when required to do so by federal, state, or local law.

- **Public Health Reporting**: We may disclose your protected health information for the public health activities and purposes to a public health authority that is permitted by law to collect or receive information.
- **Communicable diseases**: We may disclose your protected health information, If authorized by law, to a person who may have been exposed to a communicable disease or may have otherwise be at risk of contracting or spreading the disease or condition.
- **Health Oversight**: We may disclose your information to health oversight agencies for activities authorized by law such as audits, investigations, and inspections.
- **Abuse and/or Neglect**: We may disclose your protected health information to a governmental entity or agency authorized by law to receive reports of suspected abuse/neglect.
- **Food and Drug Administration**: We may disclose your protected health information to a person or company required by the FDA to report adverse events, product defects, Biologic Deviations, Etc.
- **Legal Proceedings**: if you are involved in a lawsuit, we may disclose your protected health information in response to a court order, subpoena, discovery request, or other lawful process from someone else involved in the lawsuit, but only if efforts have been made to tell you about the request to obtain an order from the court.
- **Law Enforcement**: We may disclose protected health information, so long as applicable requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death or injury has occurred as a result of criminal conduct, (5) in the event that a crime occurs on property owned or operated by Arkansas Psychiatric Clinic, and (6) in the event of a medical emergency.
- **Coroners, Funeral Directors, and Organ Donation**: we may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death, or for them to perform other duties required by law. Your protected health information may also be disclosed to a funeral director, as authorized by law, in order for the director to carry out their duties. We may disclose such information in the reasonable anticipation of death. Protected health information may be used and disclosed for cadaver organ, eye, or tissue donation purposes.
- **Criminal Activity**: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious threat to the health and safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.
- **Military Activity and National Security**: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel, (1) for activities deemed necessary by appropriate military command authorities, (2) for the purpose of determination by the department of Veterans Affairs of your eligibility for benefits, or (3) to foreign Military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities.
- **Worker's Compensation**: Your protected health information may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally- established programs.
- **Other Required Uses and Disclosures**: Under the law, we must make disclosures when required by the secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et.seq.

#### 4. YOUR RIGHTS

You have the right to inspect and obtain a copy of your protected health information. This means that you may inspect and obtain a copy of your protected health information about you that is contained in a designated record set for as long as we maintain your protected health information. A designated record set contains medical and billing records and any other records that we use in making decisions about you. You may request the record be provided in paper. You may be charged a fee for the cost of copying, mailing, or supplies associated with your request. You have the right to request a restriction of your protected health information. This means that you may ask us not to use or disclose any part of your protected health information for the purposes or treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom the restriction applies. You may also request restriction of PHI to a health plan with respect to healthcare for which you have paid for in full out of pocket. The request and payment must occur in writing in advance to the services being provided.

The physician is not required to agree to the restriction that you request, except in the case of a requested restriction of PHI to a health plan for purposes of payment or healthcare operations with respect to healthcare for which you have paid for in full out of pocket. If the physician believes that it is in your best interest to permit use and disclosure of your protected health information, it will not be restricted. With this in mind, please discuss any restriction you wish to request with your physician. You have the right to request an amendment to your protected health information. This means that you may request an amendment of protected health information about you in a designated record set for as long as we maintain the information. In certain cases, we may deny your request for an amendment. If we deny your request, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy. Please contact the clinic manager if you have questions about amending your medical record.

You have the right to receive a notice following a breach of your unsecured PHI.

#### NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

The signature below acknowledges that a copy of this notice was received (not necessarily read).

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Patient/Legal Representative Signature

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Date

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State Capacity if Legal Representative

# Arkansas Psychiatric Clinic

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## Consent for Treatment

A child aged 17 years and under must have the consent of his/her parent, custodial parent, or legal guardian to receive psychiatric services including psychotherapy, evaluation, or other treatment. In case of divorce only the custodial parent can give consent.

**So that we can comply with the law, please check ONE of the following:**

- I am the parent of the below named minor child. There has been no divorce, or legal separation proceedings between the child's other parent and myself.
- I am the custodial parent of the below named minor child as designated in divorce proceedings. I understand that I must furnish a notarized copy of the divorce decree section stating that I agree to provide this office with a notarized copy of any changes in custodial status of the child.
- I am the (custodial) parent of the below named minor child. My spouse and I have a legal separation. I have joint custody with my ex-spouse of my child.
- I am the below named child's legal guardian. I understand that I must furnish a notarized copy of the guardianship papers.
- I am the sole legal parent of the below named minor child.

I agree to inform the office if there are any changes in my child's custodial status for any reason. I hereby give my permission for Arkansas Psychiatric Clinic, P.A. to provide psychiatric services for:

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**Name of Minor Child**

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**Date**

**ARKANSAS PSYCHIATRIC CLINIC  
HIPAA COMPLIANCE AUTHORIZATION FORM FOR MINORS**

As part of this clinic's compliance with privacy regulations as set forth by the Health Insurance and Portability Accountability Act of 1996, we request that you designate individuals for the minor's physician to discuss care with.

Upon signing, I understand that the healthcare provider may discuss information pertaining to diagnosis and continuing care with the person(s) listed below.

My signature also allows these individuals to discuss medicals bills with the billing office.

I \_\_\_\_\_ hereby consent to allow the following persons to access to  
(PATIENT NAME)  
information on my account that would be considered protected health information:

**\*\*\*INCLUDE NAME OF PERSON FILLING OUT FORM BELOW\*\*\***

1. \_\_\_\_\_ Relation: \_\_\_\_\_
2. \_\_\_\_\_ Relation: \_\_\_\_\_
3. \_\_\_\_\_ Relation: \_\_\_\_\_
4. \_\_\_\_\_ Relation: \_\_\_\_\_
5. \_\_\_\_\_ Relation : \_\_\_\_\_

Patient Guardian Name: \_\_\_\_\_

Patient Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

This form is not to be substituted for a HIPAA authorization form for medical records. Copies of medical records must be processed through the clinic office staff.

## Arkansas Psychiatric Clinic Financial Policy

Thank you for choosing Arkansas Psychiatric Clinic as your healthcare provider. We are committed to providing you with the best possible care. Your clear understanding of our Financial Policy is important to our professional relationship. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. Please ask if you have any questions about our Financial Policy, fees, or your responsibility.

### Insurance Coverage

Your insurance coverage is a contract between you and your insurance company. We are not a party to that contract. If you have insurance, we will help you receive maximum benefits. If we accept your insurance, you must pay any co-payment and/or estimated coinsurance and deductibles prior to seeing the provider. In the event we accept assignment of benefits, the patient is still ultimately responsible for all charges.

### Usual and Customary Rates

Our practice is committed to providing the best treatment for patients and we charge what is usual and customary for our area. We file insurance --claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, etc., other than to provide factual information as necessary. You are responsible for the timely payment of your account.

### Nonpayment

If your account is past due, you will receive a bill and payment is due at that time or must be paid before you are seen back at the clinic. If payment isn't received for the past due balance, then you may not be able to be seen at APC.

### Missed Appointments

The clinic may charge \$50+ (or more depending on frequency of missed appointments) for appointments that are not kept or canceled with less than 24-hour notice. This policy will apply once you have missed or canceled with less than 24-hour notice following initial appointment with this clinic.

### Interpretation Services

APC partners with outside companies to provide interpretation services to patients as needed. If the appointment is kept as scheduled, the service is provided with no cost to the patient. However, if an appointment is not canceled and/or rescheduled **more than** 24 hours in advance, the patient may be responsible for the charge.

### Paperwork Completion

The provider you see at APC reserves the right to deny paperwork completion requests. The clinic may charge a nominal fee for the completion of paperwork. This charge will vary. Clinic policy requires that a paperwork completion form be filled out at the time of request. Please allow up to 10 days from the date of this request for us to complete this.

### Assignment of Insurance Benefits

I request that payment of insurance benefits be made on my behalf to **Arkansas Psychiatric Clinic** for any services furnished to me by any provider in this clinic. I authorize any holder of medical information about me to release my information needed to determine benefits to by insurance carrier, and where applicable, to the Center for Medicare and Medicaid Services and its agents. I further authorize the clinic or its agents to verify employment date and wage date in the event collection action becomes necessary.

Signature of patient or responsible party: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of co-responsible party: \_\_\_\_\_ Date: \_\_\_\_\_

*We accept cash, check, Visa, Mastercard, or Discover*



## LATE CANCELLATION AND MISSED APPOINTMENT POLICY

Thank you for choosing Arkansas Psychiatric Clinic as a provider of your healthcare needs. We would like to take this opportunity to welcome you to our clinic and explain our late cancellation and missed appointment policy.

We ask that patients who cannot keep their appointments provide us with **24-hour advance notice**. We understand there are instances when situations out of your control will present themselves, and we will waive the late cancellation or missed appointment fee the first time this occurs. However, when this happens, we are unable to care for other patients who need appointments, therefore, we do have a fee for additional occurrences. After the first late cancellation or missed appointment, there is a \$50 fee each time.

Late cancellation and missed appointment fees are billed to the patient. This fee is not covered by insurance and is not eligible for reimbursement with neither HSA nor FSA account. And it must be paid prior to your scheduling your next appointment.

We appreciate your understanding and consideration of this policy.

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**I verify I have been informed of the late cancellation and missed appointment policy.**

\_\_\_\_\_  
Print patient name

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Patient/Guardian Signature


\_\_\_\_\_  
Today's Date

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 4 Executive Center Ct., Little Rock, AR 72211

 [www.apclr.com](http://www.apclr.com)

 (501) 448-0060

 (501) 448-0066