

BAPTIST HEALTH LONOKE FAMILY CLINIC

Name: _____ DOB: _____ SS#: _____

Race: White Ethnicity: Hispanic Primary Language: English Sex: Male
Black Non-Hispanic Spanish Female
Hispanic Other: _____
Other: _____

Religion: Christian Employment: Full-time Work location: _____
Jehovah Witness Part-time
Christian Catholic Unemployed Work phone: _____
Other: _____ Student

Address: _____ City: _____ State: _____ Zip code: _____

Primary Phone: _____ Other: _____ Home/Cell

Email: _____ Primary Care Physician: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Guarantor Information (Person Responsible for Bill)

Name: _____ Date of Birth: _____ Sex: Female/Male

SS#: _____ Phone: _____ Relationship: _____

Work Location: _____ Full-time/ Part-time

Insurance Information

Primary Insurance Carrier: _____ Member ID: _____

Subscriber: _____ Subscriber DOB: _____

Secondary Insurance Carrier: _____ Member ID: _____

Subscriber: _____ Subscriber DOB: _____

I give permission to BHFC LONOKE to speak with the following individuals regarding my medical records (Lab results, insurance, appointments) if I am not available.

Name: _____ Phone: _____

Name: _____ Phone: _____

I certify that all of the above information is correct for billing purposes and it is my responsibility to notify BHFC LONOKE of any changes to my information.

Patient Signature: _____ Date: _____



Arkansas Health Group

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CLINIC GENERAL CONSENT

Arkansas Health Group is a company which employs healthcare providers and owns clinics across the state. The language in this document applies to all clinic providers and locations. Your consent for treatment will remain in effect until revoked in writing.

CONSENT: I voluntarily consent to receive medical and healthcare services from Arkansas Health Group. I understand this may include services by my physician, his or her assistants and designees, including medical students, residents or fellows, and employees of Arkansas Health Group as is deemed necessary or advisable in their judgment. I authorize the use of telehealth services, photographs, camera surveillance and/or video recordings as needed for the purpose of treatment, payment or healthcare operations. I authorize the disposal of any tissues removed in the performance of any procedure. I am aware that the practice of medicine and surgery is not an exact science; that it involves my informed acceptance of certain risks versus benefits and I acknowledge that no guarantees have been made to me as a result of my examination and/or treatments.

CONTACT BY PHONE:

COMMUNICATIONS REGARDING MY ACCOUNT:

I agree that Arkansas Health Group, any other collection or servicing agency, or agencies retained by Arkansas Health Group (together referred to hereafter as "collectors") to collect any money that I owe to Arkansas Health Group may contact me by telephone or text message at any number associated with my personal demographic information. I understand that this contact includes but is not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages.

COMMUNICATIONS REGARDING MY CARE:

I agree that Arkansas Health Group may contact me by telephone or text message at any number associated with my personal demographic information for the purpose of care coordination, quality improvement activities, appointment reminders and wellness campaign reminders. I understand that this contact includes but is not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge and agree that Arkansas Health Group may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages.

RELEASE OF INFORMATION AGREEMENT: I understand Arkansas Health Group will generate, receive and store protected health information regarding my diagnosis and /or treatment. This information could include mental illness information, use of drugs and alcohol, or communicable diseases such as HIV/AIDS. I understand that the Notice of Privacy Practices provides information about how Arkansas Health Group and its workforce may use and/or disclose my information for the purposes of treatment, payment, healthcare operations and otherwise required by law. I hereby authorize Arkansas Health Group, in its discretion, to disclose any or all of the information in my medical records to any person, corporation or agency which is or may be liable for all or part of Baptist's charge or who may be responsible for determining the necessity, appropriateness, amount, or other matter related to treatment or charges, including, but not limited to, insurance companies, health maintenance organizations, preferred provider organizations, workers compensation carriers, welfare funds, and the Social Security Administration or its intermediaries or carriers. I further authorize Arkansas Health Group, in its discretion, to disclose such information to its insurance carrier or carriers when so requested by such carrier and to my employer when said employer is actually liable for such charges.

CLINIC FINANCIAL POLICY

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.

MOTOR VEHICLE ACCIDENTS: In the event you are involved in a motor vehicle accident, you are expected to pay for services when rendered. We will gladly provide you with all the necessary paperwork to file your insurance claim with your carrier.

NON PAYMENT: If your account is over 60 days past due, you will receive a letter that you have 20 days to pay your account in full. If the balance remains unpaid, we may refer your account to a collection agency, and you and your immediate family members may be discharged from this clinic.

MISSED APPOINTMENTS AND PAPERWORK COMPLETION: The clinic will be charging a nominal fee for the completion of paperwork outside a scheduled visit. Additionally, the clinic will be charging \$25 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 the second appointment with this clinic.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign any and all rights and benefits to which I may be entitled arising out of any healthcare or liability insurance policy, Medicare or Medicaid to Arkansas Health Group. I authorize the full and undiscounted pursuit of payment on my account from any available liability insurance policy or third party source before submission of my account for payment to my own health insurance company or to



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Medicare or Medicaid. I hold Arkansas Health Group harmless of any reduction in healthcare benefits by my insurance company resulting from noncompliance with any clause or condition contained in my policy which may require: Notification; Precertification; Prior to Retrospective Authorization; or Utilization Review of the medical services I receive. Assignment of Insurance benefits is valid and binding until final payment of the account is received.

FINANCIAL RESPONSIBILITY AND PAYMENT REQUEST: The undersigned, jointly and severally, in consideration for the services rendered to the above named patient, accepts financial responsibility and agrees to pay in advance any applicable deductibles, copayments, coinsurance and estimated self pay dollars and to pay in arrears the clinic's rates and terms for services rendered to the patient upon receipt of a statement for such charges. The undersigned further agrees that if such indebtedness is placed in the hands of a collector or an attorney for collection, the undersigned will pay reasonable attorney fees, interest, court costs and other collection costs and expenses. I also understand that I may qualify for financial assistance programs and that I may secure a determination of such upon request. I further understand that such a determination is dependent upon my timely submittal of appropriate financial documentation and my failure to provide any such documentation could affect my qualification for financial assistance. I request that payment of authorized benefits be made on my behalf. I assign payment for unpaid charges for certain physicians' services furnished by specialists, and physicians for whom Arkansas Health Group is authorized to bill. I understand that I am responsible for any health insurance deductibles and coinsurance. I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I agree that I am financially responsible for deductibles and co-insurance not covered by my insurance.

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.

1. ACCESS/USE/DISCLOSURE AND YOUR PROTECTED HEALTH INFORMATION

Treatment: We will use and disclose your PHI to provide you with health care treatment or services. This includes sharing PHI among health care providers involved in your care, both inside and outside of Arkansas Health Group. Sharing PHI among providers promotes a collective, comprehensive approach to care. This communication may be accomplished by using a secure electronic method.

- Your health care provider may share information about your condition with pharmacists to discuss appropriate medications, or with radiologists or other consultants to make a diagnosis.
- Different departments may share your PHI to coordinate such things as prescriptions, dietary needs, physical therapy, social work, psychiatric support, lab work and diagnostic imaging, etc.

Your care may involve the use of telemedicine equipment. Security measures (such as encryption and/or the use of non-public networks) are used to help minimize the risks associated with telemedicine.

Payment: Your protected health information will be used, and disclosed as necessary, to obtain payment for your health care 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. For example,

- Obtaining approval from your insurance company for your admission and continued stay.

Healthcare Operations: We will use or disclose your PHI in order to support the business activities of Arkansas Health Group. These activities include, but are not limited to, quality assessment and improvement activities, training of healthcare students, licensing, risk management, legal services, compliance and audit functions, etc.

Arkansas Health Group participates in a number of online public social media sites. If you or others choose to share your health information on our online social media sites, this information is considered to be public and not protected by privacy laws, and may be re-posted or shared by Arkansas Health Group or others. If you do not want your health information to be public, you should not share it on online public social media sites. You may be contacted by Arkansas Health Group regarding fund-raising activities. Any communication will include an option to opt-out of receiving further communications.

We will share your protected health information with third party "business associates" which perform various functions for Arkansas Health Group.

Whenever an arrangement such as this involves the access/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 Arkansas Health Group and certain entities that help improve patient care and operational efficiency.
- A contract exists between Arkansas Health Group and the revenue cycle vendors who work patient accounts.

The workforce and business associates of the medical staff and other healthcare providers may also require access to your protected health information to perform their job functions. To protect your privacy, Arkansas Health Group requires written authorization from the provider before access is granted. This access may be accomplished by using a secure electronic method.

We may participate in certain health information exchanges (HIEs) whereby we may disclose your health information, as permitted by law, to other health care providers or entities for treatment, payment, or health care operations purposes.

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. For example,

- Use and disclosure of psychotherapy records
- Use and disclosure of PHI for marketing
- Disclosures that constitute the sale of PHI

You may revoke your authorization at any time in writing. There may be cases where Arkansas Health Group has already released your protected health information prior to the revocation of the authorization.

3. DISCLOSURES TO WHICH YOU HAVE THE OPPORTUNITY TO OBJECT

Facility Directory: Unless you object, we will place your name and location in our facility directory. This information will be disclosed to people who ask for you by name. Unless you object, we will maintain your religious affiliation for use by clergy of the same religious affiliation.



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Others Involved in your Healthcare: Unless you object, we may discuss your protected health information with family members or close friends. The information disclosed will only be that related directly to this person's involvement in your care. If you are unable to agree or disagree, we may disclose this information if we determine that it is in your best interest based on our professional judgment. For example,

- We may notify your family of your admission to the hospital.
- We may discuss your discharge plan with the individuals participating in your care.

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

Communication Barriers: We may use and disclose your protected health information if we are unable to obtain consent from you but feel in our professional judgment that you intend to consent.

4. 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 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 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 product deviations, etc.

Legal Proceedings: If you are involved in a lawsuit, we may disclose your protected health information in response to a court order. We may also disclose your protected health information in response to a 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 or 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 Health Group, 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 as 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.

Research: We may also disclose your protected health information to the Arkansas Health Group Center for Clinical Research to determine if you could benefit from participating in a research study. If so, you may be contacted.

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 or 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 a 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.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

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.

5. 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 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 records be provided in paper or electronic format. You may be charged a fee for the cost of copying, mailing, or supplies associated with your request. Patients are also encouraged to use the Arkansas Health Group portal to access their protected health information. Enrollment information can be found at www.baptist-health.com. Use of the portal is free.

Under federal and state law, however, you may be denied access to inspect or obtain a copy. Depending on the circumstances, the decision to deny access may be reviewable.

Please contact the medical records department at your clinic if you have any questions about access to your medical record.

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 of treatment, payment, or healthcare operations. You may 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 this restriction applies. You may also request restriction of PHI to a health plan with respect to health care for which you have paid for in full out of pocket. The request and payment must occur in writing in advance of the services being provided.

The hospital/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 health care for which you have paid for in full out of pocket. If the hospital/physician



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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 to receive confidential communication from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of any alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to the privacy contact listed below.

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 appropriate medical record department listed above if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures made for purposes outside those for treatment, payment, and healthcare operations. You have the right to receive specific information regarding non routine disclosures that occurred after April 14, 2003. We must respond within sixty (60) days. You may request a shorter timeframe. You are entitled to receive one (1) free accounting each year. There will be a fee for any additional accounting requests during the year. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

You have the right to obtain a copy of this notice from us. Upon request, you may receive an additional paper or electronic copy of this notice from us.

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

6. COMPLAINTS

If you believe your privacy rights have been violated by Arkansas Health Group, you may file a complaint with us by contacting the Baptist Health Privacy Officer at 501-202-1323. You may also file a complaint with the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint. We will not require you to waive the right to file a complaint with HHS as a condition to receive treatment from us.

7. ADDITIONAL INFORMATION

This notice was updated, published and becomes effective on August 1, 2017. Arkansas Health Group has a duty as your healthcare provider to maintain your privacy, abide by the terms of this privacy notice, and provide you with a revised copy of this notice if revisions are made.

We reserve the right to change this notice. We reserve the right to make the revised notice effective for protected health information we already have as well as any information we create or receive in the future.

NOTICE OF NON DISCRIMINATION AND ACCESS TO LANGUAGE SERVICES

Arkansas Health Group complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Arkansas Health Group does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Arkansas Health Group provides free aids and services to people with disabilities to communicate effectively with us, such as a qualified sign language interpreters and written information in other formats. Arkansas Health Group also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, please inquire with Case Coordination.

If you believe that Arkansas Health Group has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Arkansas Health Group at:

Corporate Compliance Department
9601 Baptist Health Drive
Little Rock, AR 72205
Phone: (501) 202-1326
Fax: (501) 202-1115
Email: comply@baptist-health.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Corporate Compliance Department is available to help you. You can also 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](#), or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

ENGLISH

Arkansas Health Group complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you.

SPANISH

Arkansas Health Group cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

VIETNAMESE

Arkansas Health Group tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính. CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.



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MARSHALLESE

Arkansas Health Group eo ej pokake kien an Federal in jimwe ko an armej im ejjab kalijeklōk kōn wōn armej, kaḷar, aelōñ, jete an iio, jipikpik, ak ñe emḡaan ak kōrā. LALE: Ñe kwōj kōnono Kajin Majōl, kwomaroñ bōk jerbal in jipañ ilo kajin ñe aḡ ejjelōk wōḡāān.

CHINESE

Arkansas Health Group 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。

LAOTIAN

Arkansas Health Group ປະຕິບັດຕາມກົດໝາຍວ່າດ້ວຍສິດທິພົນລະເມືອງຂອງຮູບພາບກາງທີ່ບັງຄັບໃຊ້ ແລະ ບໍ່ຈຳແນກໂດຍອີງໃສ່ພື້ນຖານດ້ານເຊື້ອຊາດ, ສີເມື່ອ, ຊາດກຳເນີດ, ອາຍຸ, ຄວາມພິການ, ຫຼື ເພດ.

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ.

TAGALOG

Sumusunod ang Arkansas Health Group sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.

ARABIC

مساعدة مات الة الاتحادية وعدم التمييز على أساس العرق أو اللون، والأصل القومي، السن، الإعاقة أو الجنس. تنبيه: إذا كنت تتحدث الإنجليزية، خذال صحة الامعدادية ي توافق مع ق واذ ين الحقوق الامندي اللغوية، مجاناً، تتوفر لك. الاتصال

GERMAN

Arkansas Health Group erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.

FRENCH

Arkansas Health Group respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.

HMONG

Arkansas Health Group ua raws cov kev caillij choj yuam siv ntawm Tsom Fwv Nrub Nrab Teb Chaw hais txog pej xeem cov cai (Federal civil rights laws) thiab tsis ciav-cais leejtwg vim nws hom neeg, nqaij tawv, lub tebchaws tuaj, hnub nyoog, kev tsis taus, los yog poj niam txiv. LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj.

KOREAN

Arkansas Health Group 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다. 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

PORTGUESE

Arkansas Health Group cumpre as leis de direitos civis federais aplicáveis e não exerce discriminação com base na raça, cor, nacionalidade, idade, deficiência ou sexo. ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.

JAPANESE

Arkansas Health Group は適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、障害または性別に基づく差別をいたしません。

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます

HINDI

Arkansas Health Group लागू होने योग्य संघीय नागरिक अधिकार कानून का पालन करता है और जाति, रंग, राष्ट्रीय मूल, आयु, विकलांगता, या पालन के आधार पर भेदभाव नहीं करता है। ध्यान दें: यदि आप हिंदी बोलते हैं तो आपको लिए मुफ्त मातृ भाषा सहायता सेवाएं उपलब्ध हैं।

GUJARATI

Arkansas Health Group લાગુ હોય તેવા સંઘીય નાગરિક અધિકાર કાયદા સાથે પુરોગત છે અને જાતિ, રંગ, રાષ્ટ્રીય મૂળ, ઉંમર, અશક્તતા અથવા પાલનના આધારે ભેદભાવ રાખવામાં આવતો નથી. યુના: જો તમે ગુજરાતી બોલતા હો, તો બિન-પરિવારિક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે.

This document shall be signed by the patient, his or her legal guardian, or by another competent individual due to the reason outlined below. The undersigned certifies that he/she has read or has been read this form, has received a copy, is the patient or authorized representative of the patient, and the conditions of admission are fully understood and accepted.

Patient/Legal Representative Signature: _____

State Capacity, if Legal Representative: _____

HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines

☐ Pollens

☐ Food

☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____

Signature of parent/guardian _____

Date _____

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Baptist Health Lonoke School Clinic form

Name _____ DOB _____ Date _____

Review of Systems (Please circle all that apply)

General: Fever, Chills, Fatigue, Weight Loss, Weight Gain

Eyes: Eye Pain, Eye Discharge, Vision Change

ENT: Ear Pain, Ear Drainage, Hearing Loss, Chronic Cough, Nasal Drainage

Cardio: Chest Pain, Palpitations, Swelling Legs

Respiratory: Cough, Shortness of Breath, Wheezing

GI: Abdominal Pain, Diarrhea, Constipation

GU: Pain with Urination, Frequency, Urgency, Discharge

Neuro: Confusion, Concussion, Numbness, tingling, Memory loss

Endocrine: Unexpected weight changes, Excessive Thirst, Hot spells

Heme-Lymph: Bleeding, Bruising, History of Transfusions

Skin: Rash, Itching, Sores, Color changes

Musculoskeletal: Back Pain, Joint Stiffness, Joint Swelling

Emotional: Depression, anxiety, Other _____

Medications:

Allergies:

Medical History: Asthma, Heart disease, Hypertension, Diabetes, Kidney disease

Other _____

Past Surgical History _____

COVID-19 Supplemental Questionnaire

Have you had any of the following symptoms in the past two weeks?

Yes No

☐ ☐ Fever

☐ ☐ Cough

☐ ☐ Shortness of breath or difficulty breathing

☐ ☐ Fatigue or difficulty with exercise

☐ ☐ Racing heart rate

☐ ☐ Unusual dizziness

☐ ☐ Loss of taste or smell

☐ ☐ Sore throat

☐ ☐ Nausea, vomiting, or diarrhea

☐ ☐ Unusual rash or painful discoloration of fingers or toes

☐ ☐ Do you have a family or household member with current or past COVID-19?

☐ ☐ Do you have moderate to severe asthma, a heart condition, chronic kidney or liver disease, or take medication or have a medical condition that weakens your immune system?

☐ ☐ Have you been diagnosed with or test positive for COVID-19 infection?