Patient Information & Informed Consent

Patient Social Sec. #_____ **Marital Status**: Single Married Divorced Widowed

Name **Gender** **Date of Birth** **Age**

Mailing Address **City** **Zip** **Telephone#**

Name of Insurance Co. **Group #** **Subscriber #**

Address for filing claim

Person responsible for billing payments (Guarantor) **Guarantor Date of Birth** **Guarantor Social Sec. #**

Address **Telephone #** **Cell Phone #**

Name of Employer **Occupation** **Address** **Telephone#**

Emergency Contact **Relationship** **Telephone #**

Secondary Emergency Contact **Relationship** **Telephone #**

1. During the past 24 months, have you or the family member upon whom you are dependent:

-done farm work year-round/seasonal? YES NO

-moved (established a temporary residence) in order to do farm work? YES NO

2. In order to determine eligibility for patient assistance programs and for federal reporting necessary to continue funding for this facility, please complete: Number of Household Dependents: _____ Gross Household Income: $_____

Financial Assistance: In an effort to ensure that payment of fees is not a barrier to care, Mainline Health Systems, Inc. may consider a waiver of fees. _____ **YES**, I request a waiver of fees . _____**NO**, I do not request a waiver of fees.

3. Please circle any options that apply to the patient: Veteran Homeless Live in Public Housing Migrant None

4. Is the patient of Hispanic/Latino ethnicity? YES NO

5. Please select the patients **Race:** __White/Caucasian __African American/Black __ Hispanic/White __Asian
__Native Hawaiian __ American Indian __ Other Pacific Islander __Refuse to Report

6.Mainline Health Systems, Inc. is dedicated to providing primary care, dental and mental health services to all of our patients. Because physical and emotional problems often go together, we at Mainline Health Systems, Inc. believe the best care is given when health care providers work together. Mainline Health Systems, Inc. patients may be referred to providers from other health care specialties within the MHSI team; members of the treatment team will share clinical information with each other as it is clinically necessary and relates to your treatment.

7. I _____, the _____ of_____
(**Name of person giving consent)** **(Relationship)** **(Patient)**
hereby voluntarily consent to outpatient care encompassing routine diagnostic procedures, examination, integrated medical care and dental treatment including (but not limited to) routine laboratory work (such as blood, urine and other studies), taking of X-ray, heart tracing, administration of medications prescribed by the provider, and/or behavioral health services.

7. (a) I further consent to the performance of those diagnostic procedures, examinations and rendering of medical, dental, and/or behavioral health treatment by the medical, dental, and behavioral health staff, including nurses, assistants, hygienists, behaviorists and/or other staff as

is necessary per provider judgment. (b) I understand, that if I am 18 years or older, I may consent for all health services; otherwise my parent or legal guardian will need to consent for services. (c)) I understand some services at Mainline Health Systems may involve the use of telemedicine equipment and interaction with providers who are not physically onsite for consultation. These sessions are transmitted via secure, dedicated high speed lines and are not videotaped or saved in any way. I understand that the information gathered is strictly used for treatment purpose at Mainline Health Systems and will be maintained in Mainline Health Systems records only.

8. Release of Information: (a) I authorize the clinic to release medical, dental, and behavioral health information to the third party insurance carriers for the purposes of filing insurance claims related to my (his/her) care and understand that I may be billed for services rendered. (b) I further authorize the release of all health information about treatment here to my (his/her) doctor or any designated by me. (c) I further authorize the ability to view prescriptive history from external sources. (d) I further authorize the release of health information to federal and state governing entities for the purposes of required reporting.

9. I understand that this consent form will be valid and remain in effect as long as I (he/she) attend the clinic.

10. This form has been fully explained to me and I understand its contents.

_____ _____

Signature of patient or person authorized to consent for patient

Signature of person who explained the contents of this consent form (MHSI EMPLOYEE)

_____

Date

If the patient is a minor or is unable to consent, complete the following:

A. Patient is a minor_____ years of age.

_____ _____

Father's Name

Mother's Name

B. Patient is unable to consent because_____.

_____ _____

Signature of patient or person authorized to consent for patient

Relationship

ABOUT OUR NOTICE OF PRIVACY PRACTICES

We are committed to protecting your personal information in compliance with the law. The attached Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may use and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and discloses not described in this Notice.
- The person to contact for further information about our privacy practices.

Mainline Health Systems, Inc. Participates in the State Health Alliance for Records Exchange (SHARE). SHARE is a way of sharing your health information statewide among your doctors, hospital, labs, radiology centers, and other health care providers through secure, electronic means. With access to your up-to-date health information, your doctor can provide safer, more effective healthcare tailored to your personal medical needs. If you wish to opt-out, please ask your care team for an Opt-Out form. You can also opt-out for your minor child (under the age of 18) using the same process.

Mainline Health Systems, Inc. Notice of Privacy Practices provides the above information regarding disclosures of protected health information. Your signature below indicates that you have been provided with a copy of the notice of privacy practices.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Legal Representative (if applicable) Date

_____
_____
_____
Description of Legal Authority to Act on Behalf of Patient (if applicable)

_____ _____
Signature of MHSI Employee Date

RELEASE OF INFORMATION

Authorization to Share Protected Health Information

As a patient of Mainline Health Systems, Inc. we are obligated to protect your health information. By law, we cannot discuss your health information with anyone but you unless we have written consent that authorized us to do so. If you have family and/or friends that you would like us to share your personal health information with, please list them below. A child's (under age 18) health information may be discussed with their legal parent of guardian without a signed authorization.

The following individuals <u>MAY BE TOLD</u> about my personal health information, illness, and/or treatment. We must have a secure means to make sure that we are actually speaking to the correct person. Please list the person's name, relationship, date of birth, and last 4 numbers of their social security number. They will be asked this information before any information will be released to them. If there is no one that you wish to list, then please mark N/A or not applicable .

1. Name _____Relationship _____

   Date of Birth _____Last 4 numbers of Social Security _____

2. Name _____Relationship _____

   Date of Birth _____Last 4 numbers of Social Security _____

3. Name _____Relationship _____

   Date of Birth _____Last 4 numbers of Social Security _____

Please list a phone number where we may contact YOU to inform you of test results, a medication change, diet change, etc.

Home _____ Cell _____

Work _____ Other _____

_____ _____

Patient Signature **Date**

_____ _____

MHSI Employee Signature **Date**

Updated/Reviewed: 3/2021

Provider Selection Form

Please select your Provider of choice/PCP from the list below. The providers are listed by primary clinic site.

PLEASE NOTE: YOU MAY CHOOSE ONLY *ONE* PROVIDER

* Notes scheduled rotation to multiple clinic sites.

MAINLINE DERMOTT, Dermott, AR

___William Hunter, DNP, APRN
___ Kim Weeks, APRN*
___ Brenda Jacobs, DNP, APRN *

MAINLINE WILMOT, Wilmot, AR

___ Dustin Strickland, APRN

MAINLINE STAR CITY, Star City, AR

___ Amy White, APRN
___ Kendal Noble, APRN
___ Paul Whipple, MD
___ Charlie Gober, APRN *

MAINLINE EUDORA, Eudora, AR

___ Clark Roberts, APRN
____ Toni Stephens, APRN*

MAINLINE MONTICELLO, Monticello, AR

___ Crystal Little, MD
___ Jesse Bone, APRN
___ Holley Shelton, APRN
___ Brenda Jacobs, DNP, APRN*

SCHOOL BASED CLINIC- HAMBURG, Hamburg, AR

___ Shenika Jackson-King, APRN

SCHOOL BASED CLINIC- PORTLAND, Portland, AR

___ Myra Flemister, APRN

SCHOOL BASED CLINIC- LAKE VILLAGE, Lake Village, AR

___ Courtney Johnson, APRN
___ Sandlin Rhoads, RDH*

SCHOOL BASED CLINIC- DREW CENTRAL, Monticello, AR

___ Dana Phillips, APRN

MAINLINE WARREN, Warren, AR

___ Kerry Pennington, MD
___ Joe Wharton, MD
___ Heath Reep, APRN
___ Karen Richardson, APRN
___ Tammy Green, APRN

MAINLINE PORTLAND, Portland, AR

___ Myra Flemister, APRN

MAINLINE RISON, Rison, AR

____ Kimberly Golden, MD
____ Michelle Rawls, APRN

SCHOOL BASED CLINIC-EUDORA, Eudora, AR

___ Clark Roberts, APRN

SCHOOL BASED CLINIC- DERMOTT, Dermott, AR

____ Kim Week, APRN *
____ Hillary Montgomery, RDH*

SCHOOL BASED CLINIC-STAR CITY, Star City, AR

____ Leah Williams, APRN
____ Hillary Montgomery, RDH*

I understand I have chosen the above marked provider as my Provider of choice/PCP and I understand future appointments will be scheduled with him/her to ensure continuity and improved delivery of care. In the event my provider is unavailable, my appointment may be scheduled with another provider. I understand I have the right to request to change my Provider of choice/PCP to a different Provider in accordance with MHSI policy.

_____ _____
Print Patient Name Date

_____ _____
Patient's Signature Parent's Signature or Patient's Representative

Patient Portal User Agreement

Mainline Health Systems, Inc. provides a secure patient portal via the internet that is designed to enhance patient, physician, and care team communications and improve patient care and satisfaction.

Mainline Health Systems, Inc. strives to keep all of the information in your records updated, complete and secure. Secure messages and information on the patient portal can only be read by someone who has access to the correct password to log onto the portal site.

The Patient Portal is designed to provide the following services:
1. Access and view your Personal Health Record (PHR)
2. Email secure, non- emergent needs to the care team.
3. Request a referral
4. Update your demographic information
5. Request an appointment
6. View limited lab results
7. Request a refill on your medications

Please note:
The patient portal is not for use to communicate emergencies, triage, to provide treatment, or refill certain medications or narcotics.

It is the responsibility of the patient to keep unauthorized individuals from learning their passwords and allowing access to their email information or portal account. It is also the responsibility of the patient and/or guardian to notify Mainline Health Systems, Inc. of any email address changes. Mainline Health Systems, Inc. offers patient portal access to patients 18 years and older or to the legal guardian of a minor child. Mainline Health Systems, Inc. provides the patient portal as a courtesy to our valued patients. If abuse or negligent usage is suspected, Mainline Health Systems, Inc. reserves the right at our own discretion to terminate patient portal offering, suspend user access, or modify services offered through the patient portal.

PLEASE SELECT AN OPTION BELOW:

[ ] **I do wish to participate** in the patient portal and therefore acknowledge and have read and fully understand the above agreement and certify that I am 18 years or older or that I am the legal guardian of the minor patient.

EMAIL : _____

[ ] **I do NOT wish to participate** in the patient portal.

_____ _____
Patient Name (PRINT ONLY) Patient Signature

_____ _____
MHSI employee Date

A picture ID is required for the following:

[ ] I wish to deactivate my patient portal account.
[ ] I wish to unlock my patient portal account.
[ ] I wish for my password to be reset on my patient portal account.

_____ _____
Patient Name (PRINT ONLY) Patient Signature

_____ _____
MHSI employee Date