SALEM FAMILY PRACTICE CLINIC, P.A. **2020**
PATIENT INFORMATION

First Name: ____________________ Last Name: ____________________ Middle Name: ______________

Date of Birth: _____/_____/_____ Circle One: **Male or Female** Marital Status: **S / M / D / W**

Address: Street______________________________ City: ______________ State: ________ Zip: ________

Home Phone: ( ) _____-________ Cell Phone: ( ) _____-________ SS# ______-______-______

Spouse's Name: ______________________________ Phone Number: ( ) _____-________

Patient E-Mail: ______________________________

Race: ☐ White ☐ African American ☐ Asian ☐ Native American Indian/Alaska ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Decline

Ethnic Group: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline

Primary Language: ☐ English ☐ Spanish ☐ Other_____

Employer: ______________________________
Employer Address: ______________________________
City, State, Zip: ______________________________
Phone Number: ( ) _____-________

Emergency Contact:
Name: ______________________________
Relationship: ______________________________
Phone Number: ( ) _____-________

IF PATIENT IS A MINOR PLEASE COMPLETE MOTHER AND FATHERS INFORMATION:

Mother's Name: ______________________________
Date of Birth: ____/____/____ SS#: ____________
Address: ______________________________
City, State, Zip: ______________________________
Employer: ______________________________
Phone Number: ( ) _____-________

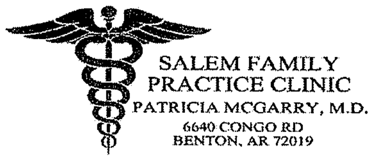
Father's Name: ______________________________
Date of Birth: ____/____/____ SS#: ____________
Address: ______________________________
City, State, Zip: ______________________________
Employer: ______________________________
Phone Number: ( ) _____-________

Insurance

Primary Insurance Company: ______________________________
Policy ID or Number: ____________________ Group Number: ____________________
Policyholder's Information:
Name ____________________ Address: ______________________________ Relationship: __________
DOB: __________ Circle One: **Male or Female** SS# ____________ Phone Number: ( ) _____-________

Secondary Insurance Company: ______________________________
Policy ID or Number: ____________________ Group Number: ____________________
Policyholder's Information:
Name ____________________ Address: ______________________________ Relationship: __________
DOB: __________ Circle One: **Male or Female** SS# ____________ Phone Number: ( ) _____-________

Patient/Guarantor Signature ______________________________ Date ____________


SALEM FAMILY
PRACTICE CLINIC
PATRICIA MCGARRY, M.D.
6640 CONGO RD
BENTON, AR 72019

Salem Family Practice Clinic, P.A. is dedicated to providing you fast and reliable information concerning your care. In many cases, we may not be able to talk to you directly because you may be away from your telephone. A convenient alternative is to leave you a message for you to check later at your convenience. However, these messages may contain confidential issues.

I authorize the staff of Salem Family Practice Clinic, P.A. to leave and transmit confidential information to one or more of the following:

Answering machine at the home telephone of ( ) - . Yes No

Voice mail on cell phone of ( ) - . Yes No

Text Messaging Updates/Appointment Reminders on cell phone. Yes No

Email Updates/Appointment Reminders at: ______________________ Yes No

IN ORDER FOR ANYONE, OTHER THAN YOURSELF, TO RECEIVE ANY OF YOUR MEDICAL INFORMATION, PLEASE FILL OUT THE PORTION BELOW

I authorize Salem Family Practice Clinic, P.A. to share "Protected Health Information' with my family members or significant others, as noted below:

1. Name: ______________ Relationship: ______________ Phone Number: ( ) ____-______
2. Name: ______________ Relationship: ______________ Phone Number: ( ) ____-______
3. Name: ______________ Relationship: ______________ Phone Number: ( ) ____-______

I understand that I may withdraw the above authorization at any time, with written request. I also understand that it is my responsibility to inform all family members or significant others to not to disclose any information at any time or in any way without my written permission.

Patient Signature ______________________ Date ______________

SALEM FAMILY PRACTICE CLINIC
OFFICE POLICIES

MISSED APPOINTMENTS

If you are a new patient and miss your first visit, we will not reschedule.

Three (3) missed, no-show appointments will result in dismissal from the practice.

There will be a $25 charge for a missed appointment.

We understand appointments sometimes need to be changed, so we ask that you please call our office in advance if you cannot keep your scheduled appointment.

PHONE CALLS

Please allow up to 24 hours to receive a phone call back.

Usually all phone calls are returned the same business day. Phone calls after 4:30pm are returned the next day.

LAB WORK

For the convenience of the patients and the staff here at Salem Family Practice, <u>we will call to provide the results only if there is a problem.</u>

If you would like a copy of your lab results you may bring in a stamped self-addressed envelope with you to your appointment and once the results come in we will mail you the results OR you may stop in our office to pick up a copy at your convenience.

WE CAN NOT ACCEPT LAB ORDERS FROM OTHER DOCTORS OR FACILITIES

MEDICATION REFILLS

For refills on medications please call your pharmacy first.

MEDICATIONS

Salem Family Practice Clinic does **not** offer chronic pain management and will **not** prescribe chronic pain medications. For example, daily chronic narcotics or Xanax. We will provide you with a referral to a pain management center if you need this specialized form of care after evaluation by Dr. McGarry.

Here at Salem Family Practice we participate in the **Arkansas Drug Monitoring Program**. This program provides complete and detailed reports of all prescriptions that each and every patient receives at their pharmacy or pharmacies. The goal of this program is to enhance patient care and ensure legitimate use of controlled substances.

I have read and agreed to Salem Family Practice's office polices listed above:

Patient Signature: ______________________________ **Today's Date:** __________

SALEM FAMILY PRACTICE CLINIC

2020

MEDICATION LOG

Patient Name______________________________ DOB_____/_____/______

Home Ph (_____)_______-__________ Cell Ph (_____)_________-____________

Pharmacy Name______________________ Pharmacy Ph (___)______________

PLEASE INCLUDE ALL MEDICATIONS YOU ARE CURRENTLY TAKING

Medication Name	Strength	Quantity	Frequency

Please list any medication allergies:

____

____

Confidential

Patient Name ______________________ Today's Date ______________

Age ______ Birthdate ______________ Date of last physical examination ______________

What is your reason for visit? ______________________

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period ________

Date of last Pap Smear ________

Have you had a mammogram? ________

Are you pregnant? ________

Number of children ________

Conditions

Check (✓) conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

Medications

List medications you are currently taking.

____

____

____

____

Pharmacy Name ______________ Phone ______________

Allergies

____

____

____

____

____

Health History

Family History

Fill in health information about your immediat[illegible]nily.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓)	Disease	Relationship to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Strokes	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

Check (✓) if, your blood relatives had any of the following:

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates ____________________

Serious Illness/Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✓) which you use and how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

Occupational

Check (✓) if your work exposes you to:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation ____________________

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

____________________ Signature of Patient, Parent, Guardian or Personal Representative

____________________ Date

____________________ Please print name of Patient, Parent, Guardian or Personal Representative

____________________ Relationship to Patient

____________________ Reviewed By

____________________ Date

SALEM FAMILY PRACTICE CLINIC, P.A.

DR. PATRICIA MCGARRY, M.D. | PH: (501) 794-4110

6640 CONGO ROAD BENTON, AR 72019 | FAX: (501) 316-9360

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Information:

Name: ______________________________ DOB: _____/_______/______

Address: Street______________________________ City: ____________________

State: ______________ Zip: ______________ Social Security #:________-______-________

I authorize to release my medical records to or from the following:

Name or Facility: ______________________________ Ph. #:____________________

Address: ______________________________ Fax #:____________________

This Request and authorization applies to (check one):

- ○ Healthcare information relating to the following treatment, condition or dates:

  ____

- ○ All healthcare information

- ○ Other: ____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., included herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

○ Yes ○ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

○ Yes ○ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient's Signature: ______________________________ Date Signed: ______________

NOTICE OF PRIVACY PRACTICES

Salem Family Practice Clinic, P.A.

6640 Congo Rd, AR 72019

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

Our Privacy Commitment

Thank you for giving us the opportunity to serve you. In the normal course of business – providing medical care to you Salem Family Practice Clinic, PA creates records about you and the treatment and services we provide to you. The information we collect is called Protected Health Information (PHI). We take our obligation to keep your PHI secure and confidential very seriously.

We are required by federal and state law to protect the privacy of your PHI in your healthcare records and any other identifiable patient health information used or disclosed by us in any form and provide you with this Notice about how we safeguard and use it. We are also required by law to notify you following a breach of your unsecured PHI.

When our office, its employees, Business Associates and other involved parties use or disclose your PHI, we are bound by the terms of this Notice that is currently in effect. This Notice applies to all electronic or paper records we create, obtain and/or maintain that contain your PHI, including clinical notes, lab results, x-rays and medication history.

After reading this Notice, we will need your signature on a written, dated Consent or Acknowledgement Form before we will use or disclose your PHI for certain purposes. You may request and receive a copy of this Notice. You may take back or revoke your consent or authorization at any time (unless we have already acted based on it) by submitting to us in writing a revocation. Your revocation will take effect when we receive it. It will not affect what we have already used or disclosed in our reliance on your consent.

If you do not sign our Authorization/Acknowledgement Form or if you revoke it in the future, your PHI may be used or disclosed as permitted or required by law.

This Notice of Privacy Practices is NOT an authorization.

How We Protect Your Privacy

We restrict access to your PHI to authorized workforce members (employees, volunteers, trainees and business associates) who need that information for your treatment, for payment purposes, and/or for health care operations. We maintain technical, physical and administrative safeguards to ensure the privacy of your PHI.

To protect your privacy, only authorized and trained workforce members are given access to our paper and electronic records and to non-public areas where this information is stored. Our workforce members are trained on HIPAA and the privacy and data protection required for PHI as well as maintaining technical, physical and administrative safeguards in place to maintain the privacy and security of your PHI. Should you have any questions, please ask to speak to our (privacy officer) Nancy Shipe.

How We Use and Disclose Your PHI

Uses/disclosures of your PHI without your authorization

- Treatment:
  - To coordinate your healthcare and services with a different healthcare facility or professional.
  - To share with nurses, doctors, pharmacies, health educators and other health care professionals so they can determine a plan of care.
  - To consult with your family or others so they may assist you with home care.
  - Arrange appointments with other healthcare providers; schedule lab work, etc.
- Payment
  - To verify insurance coverage and/or receive authorization for a procedure.
  - To submit claims to your health plan or third party for payment.
  - To bill or collect payment from you.
  - You may restrict disclosure to your insurance carrier for services if you pay "out of pocket" in full for the services.
  - To coordinate benefits with other coverage you may have.
- Healthcare Operations
  - To provide customer service such as appointment reminders, calling you by name in the waiting room, placing your name on a sign-in sheet, recommending or informing you of health-related products and complementary or alternative treatments that may interest you. If you prefer we not contact you with appointment reminders or information about treatment alternatives or health-related products and services, you may notify us of this in writing and we will not use or disclose your PHI for these purposes.
  - To support and/or improve the programs or services we offer you.
- Disclosure to Other Individuals in Your Health Care
  - To family members but only if you are present and verbally give permission.
  - If you are in an emergency situation and are not present or are incapacitated, we will use our professional judgment and the surrounding circumstances to decide whether disclosing your PHI to others is in your best interest. If we do disclose your PHI in a situation where you are unavailable, we will only disclose information that is directly relevant to your treatment or for payment related to your treatment. We may also disclose your PHI in order to notify or assist in notifying such persons of your locations, your general medical condition, or your death.
  - We may disclose your child's PHI to your child's other parent.
  - <u>If you do not want us to disclose your PHI or your child's PHI to others, please let us know</u>
  - You may name another individual to act as your personal representative. Your representative will be allowed access to your PHI, to communicate with the health care professionals and facilities providing your care and to exercise all other HIPAA rights on your behalf. Depending on the authority you grant your representative, this person may also have authority to make health care decisions for you.

- **Special situationswhen your PHI will be disclosed/used without your authorization:**

    - As Required by Law
        - E.g., child and elder abuse, domestic violence
    - To Avert a Serious Threat to Health or Safety of the Public or another Person.
    - Business Associates
        - We may disclose PHI to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services.
    - Organ and Tissue Donation
        - If you are an organ donor, we may use or disclose PHI to organizations that handle organ procurement
    - Military and Veterans
        - If you are a member of the armed forces, we may disclose PHI as required by military command authorities.
    - Worker's Compensation
        - We may disclose PHI for workers' compensation or similar programs.
    - Federal or State Government health-care oversight activities
        - i.e., civil rights laws, fraud and abuse investigations, audits, investigations, etc.
    - Lawsuits and Disputes
        - If you are involved in a lawsuit or dispute, we may disclose PHI in response to a court order or administrative order, subpoena, discovery request or other lawful process. We will make every effort to tell you of the request.
    - Law Enforcement
        - In response to a court order, subpoena, warrant, summons or similar process;
        - Limited information to identify or locate a suspect, fugitive, material witness or missing person;
        - About the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement;
        - About a death we believe may be in the result of criminal conduct;
        - About criminal conduct on our premises; and
        - In an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.
    - Correctional Institution
        - If you are or become an inmate of a correctional institution, we may disclose PHI to the institution or its agents when necessary for your health or the health and safety of others.
    - National Security and Intelligence Activities
        - We may release PHI about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.
    - Coroners, Medical Examiners and Funeral Directors
        - This may be necessary, for example, to identify a deceased person or determine the cause of death.
        - We also may release PHI to funeral directors as necessary for their duties.
    - For Research
        - Those projects approved by a review board to ensure confidentiality; you will be asked to sign an authorization.

Uses of PHI that require your authorization

Other uses and disclosures as set forth below will be made only with your consent, authorization or opportunity to object unless required by law. The following categories of information that are marked with an * are considered sensitive and require enhanced privacy protection:

- Psychotherapy notes *
- Alcohol and drug abuse prevention, treatment and referral notes *
- HIV/AIDS testing, diagnosis or treatment *
- Any PHI that contains genetic information that will be used for underwriting purposes *
- PHI that is used for marketing purposes
- Disclosures that constitute a sale of your PHI

YOUR INDIVIDUAL RIGHTS

You have the following rights regarding the PHI that we create, obtain, and/or maintain for you.

1. Obtain a paper copy of the Notice upon request. At your request, we will provide you with a copy of this Notice. We are required to follow the terms of this Notice currently in effect but reserve the right to change the terms of our Notice at any time.

2. To inspect and copy your PHI. You may request in writing to review or receive a copy of your PHI that is included in certain paper or electronic records we maintain. Under limited circumstances, we may deny you access to a portion of your records. All original records will remain on the premises and will only be available for inspection during regular business hours. You will have the right to request a copy in electronic format if your health record is maintained electronically. If your PHI is maintained in electronic format but is not readily producible in such format, we will produce it in a readable electronic format upon which we agree. We have the right to charge a reasonable fee for paper or electronic copies.

3. Right to request restrictions. You may ask to restrict the way we use and disclose your PHI for treatment, payment, and health care operations as explained in this Notice. We are not required to agree to the restrictions. If we agree to the restrictions, we will follow them except in an emergency where we will not have time to check for limitations, in which case we will ask the receiving person not to further use or disclose your PHI.We will honor your request to restrict information to your health plan or insurer about a visit, service or prescription for which you have paid in full provided that disclosure is not otherwise required by law. You may exercise this right at the time of service. If you do so, no claim or communication with your health plan or insurer will occur.

4. Right to receive notice of a breach. You have the right to be notified upon a breach of any of your unsecured PHI.

5. Right to amend your records. You may ask us to correct or amend your PHI contained in our electronic or paper records if you believe it is inaccurate or something is missing. We will act on your request within 30 days from receipt of a written request. If we determine the information is inaccurate, we will notify you in writing and make the changes by noting (not deleting) what is incorrect or incomplete and adding the changed language. We may deny your request under certain circumstances. If we deny your request, we will notify you in writing and you may file a complaint with us if you disagree. If you are not satisfied with our decision, you may complain to the U.S. Department of Health and Human Services. If a different health care facility or professional created the information that you want changed, you should ask them to amend the information.

6. Right to receive confidential communications. You may ask us in writing to communicate with you in a different way or at a different place. We will accommodate all reasonable requests whenever feasible.

7. Right to receive an accounting of disclosures. Upon your written request, we will provide a list of the disclosures we have made of your PHI for a specified period of time. However, the list will exclude:

a. Disclosures you have authorized.
b. Disclosures made earlier than six (6) years before the date of your request or three (3) years in the case of disclosures made from an electronic health record.
c. Disclosures made for treatment, payment and health care operations purposes.
d. Disclosures as excepted by law.
e. Disclosures to you or to your personal representative.
f. Disclosures incidental to a use or disclosure that is otherwise permitted or required by law.

Your request must state in what form you want the list (paper or electronically) and the time period you want us to cover. If you request an accounting more than once during any 12 month period, we will charge you a reasonable fee for each accounting report after the first one.

ACTIONS YOU MAY TAKE

Contact us. If you have any questions about your privacy rights, believe that we may have violated your privacy rights or disagree with a decision that we made about access to your PHI, you may contact us at the following address or telephone number.

Our Privacy Officer: _Nancy Shipe
Office Name: _Salem Family Practice Clinic, PA
Office Address: _6640 Congo Road, Benton, AR 72019
Office Phone: _501-794-4110

Contact a government agency. If you believe we may have violated your privacy rights, you may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services (HHS). Your complaint can be sent by email, fax or mail to the HHS' Office for Civil Rights (OCR). You will not be retaliated against for filing a complaint. For more information, go to the OCR website www.hhs.gov/ocr/privacy/hipaa/complaints . Mailed complaints may be directed to:
Office of Civil Rights
Region IV
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, Texas 75202
Fax: 1- 214-767-0432

NOTICE AVAILABILITY AND DURATION

Notice Availability. A copy of this Notice is available from our office(s) and is posted in prominent locations in our office at all times.

Right to change terms of this Notice. We may change the terms of this Notice at any time, and we may, at our discretion, make the new terms effective for all of your PHI in our possession, including any PHI we created or received before we issued the new Notice.

If we change this Notice, we will give you the new Notice when you receive treatment. In addition, we will post any new Notice in a prominent location in our office(s).

Effective Date. These privacy practices are in effect as of November 1, 2014, and will remain in effect until we revise them as permitted or required by law.