NO REFILLS FOR NARCOTIC PAIN MEDICINES

The doctors of The Leslie clinic will not refill prescriptions written by other physicians for narcotic pain medications, including but not limited to the following:

Ativan * Darvocet

Hydrocodone * Lortab

Methadone * Oxycodone

Vicodin * Xanax

Diet Pills

The Leslie Clinic New Patient Questionnaire

Thank you for your interest in The Leslie Clinic. In order for our physicians to provide you with the best possible care we need to get your medical history. Please fill out this New Patient Questionnaire completely and return it to our office as soon as possible for the Physician to review.

Name: _____ Date of Birth: _____

Address: _____ Male ☐ Female ☐

_____ Primary Language: _____

Home Phone: _____ Work Phone: _____ Ethnicity: _____

Cell Phone: _____ Email address: _____

In Case of Emergency, Notify: _____ Primary Insurance: _____

Date of last Pneumonia Vaccine: _____ Date of last Flu Vaccine: _____

Allergies: Please list any drug, food, substances to which you have had an allergic or bad reaction.

If there are no known allergies, please check this box: ☐

Allergy	Reaction Experienced

Current Medications

Please list any prescription medications, over the counter medications, vitamins, herbs or nutritional supplements that you are now taking. Please include the dosage amount, the frequency taken, the prescribing physician and any drug sensitivities.

If you do not take any medications or supplements, please check this box. ☐

What Pharmacy/Pharmacies do you use?

Medication Name	Dosage	How often do you take this Medication?	Prescribing Physician

Physicians & Other Healthcare Providers involved in your care: Please include former Primary Care Physicians.

Name	Telephone	Specialty

New Patient Questionnaire

Medical / Surgical History: Please list an illness/Operations/Injuries and the dates on which they occurred.
If you have not had any surgeries/illnesses/injuries, please check this box ☐

Procedure/Illness	Date of Surgery/Illness began

Social History

Have you ever smoked? Yes ☐ No ☐ Packs per day? _____ How many years have you smoked? _____ Years

If you are a Former Smoker, when did you quit? _____

Do you use other forms of Tobacco? Yes ☐ No ☐ How often/How much? _____

Do you drink alcohol? Yes ☐ No ☐ How often/How much? _____

Do you use illegal drugs? Yes ☐ No ☐ How often/How much? _____

Medical History

Have you ever been treated for:

Anemia	☐	Epilepsy	☐	Liver Disease	☐
Arthritis	☐	Glaucoma	☐	Leukemia	☐
Asthma	☐	Heart Disease	☐	Lung Disease	☐
Alcohol Problems	☐	Heart Murmur	☐	Lupus	☐
Bleeding Tendency	☐	Hepatitis	☐	Rheumatic Fever	☐
Cancer	☐	High Blood Pressure	☐	Stroke/TIA	☐
Congenital Heart Problem	☐	High Cholesterol	☐	Tuberculosis	☐
Depression	☐	Jaundice	☐	Thyroid Disease	☐
Diabetes	☐	Kidney Disease	☐	Ulcers	☐

Other Health Problems: _____

Family Medical History

Do you have a Family History of:

Diabetes	☐ YES	☐ NO	Family Member affected :	_____
Heart Disease	☐ YES	☐ NO	Family Member affected :	_____
Hypertension	☐ YES	☐ NO	Family Member affected :	_____
Cancer	☐ YES	☐ NO	Family Member affected/Type :	_____
Kidney Disease	☐ YES	☐ NO	Family Member affected :	_____

Are your parents still living?

Father: ☐ YES ☐ NO Age at death _____ Cause of Death _____

Mother: ☐ YES ☐ NO Age at death _____ Cause of Death _____

Do you have Siblings?/How many? ☐ YES ☐ NO _____ Sisters _____ Brothers

Do you have Children?/How many? ☐ YES ☐ NO _____ Daughters _____ Sons

How did you hear about The Leslie Clinic? _____

Please visit our website at www.theleslieclinic.com
Ask our receptionist for your Username and Password to access the Patient Portal

Welcome to your HealthCare Support Portal	
Your HealthCare Support Portal facilitates better communication with your physician's office by providing convenient 24 x 7 access from the comfort and privacy of your own home or office.	
Using your secure portal you will be able to:	**Manage your personal information.**
Communicate with the practice, securely and efficiently.	**Review your lab results and statements.**
Request appointments, see date and time of upcoming appointments.	**Request a prescription refill from a pre-populated list of currently refillable prescriptions.**

THE LESLIE CLINIC, PA

306 NORTH CHESTNUT STREET, HARRISON, AR 72601

PROVIDING OUALITY HEALTHCARE FOR YOUR FAMILY

HOME PAGE OUR PRACTICE STAFF SERVICES CONTACT US LOCATION LINKS FORMS CALENDAR

Home Page

The Leslie Clinic is a full service medical clinic that has been serving North Arkansas for the past 25 years. We take pride in providing comprehensive medical care for the entire family.

Office Hours:

Monday - Friday

8:00 AM to 4:30 PM

Walk In's are welcome but to facilitate a more prompt visit please call for appointment, same day appointments are available.

Most Major Insurance Plans are Accepted

Call or email for information

The Leslie Clinic, PA
306 North Chestnut St
Harrison, AR 72601
(870) 741-8559

contact@theleslieclinic.com

Visitor Number

Click here for access to the Patient Portal
Click here for Preregistraton

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

BY SIGNING BELOW I GIVE PERMISSION, WITHOUT LIMITATION OR EXCLUSION, FOR THE LESLIE CLINIC, P.A. AND IT'S PROVIDERS TO VIEW MY EXTERNAL PRESCRIPTION HISTORY IN BOTH MULTUM AND MEDI-SPAN DATABASES FOR PURPOSES OF MY CARE AND TREATMENT. I UNDERSTAND THAT MY MEDICATION HISTORY FROM MULTIPLE OTHER MEDICAL PROVIDERS, INSURANCE COMPANIES, AND PHARMACY BENEFIT MANAGERS MAY BE VIEWABLE AND THAT GRANTING THIS PERMISSION WILL ALLOW MY PROVIDERS TO BETTER COORDINATE MY CARE AND TO MAXIMIZE THE EFFECTIVENESS AND SAFETY OF MY TREATMENT PLAN.

I certify that I read and understand the scope of my consent and that I authorize access.

****Signature of Patient or Representative**: _____

☐ Self ☐ Parent ☐ Legal Guardian ☐ Representative/Health Care POA

Date: _____ Time:_____am/pm

THE LESLIE CLINIC P.A.
306 N. CHESTNUT ST.
HARRISON, AR 72601
Clinic (870) 741-8559
Fax (870) 741-1798

Thomas S. Leslie, M.D.
Family Medicine

David A. Stills, M.D.
Family Medicine

Phone Messages

We use phone messages to contact patients with a wide variety of notifications, general notifications, cancellation notices, changes in office hours, and a host of other messaging options. In order for the clinic to send you Phone Messages we need your permission and your contact preferences.

Preferred phone number to receive Phone Message:
☐ Home: _____ ☐ Cell: _____ ☐ Work: _____

Additional option: May we contact you by
☐ Email: _____
☐ Text Msg Carrier: _____ Number: _____

What is the best time to receive Phone Messages:
☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time

Preferred language:
☐ English ☐ Spanish

If you do not wish to utilize this service, just check the box below:
☐ No, I do not wish to utilize eMessenger.

_____ _____
Patient/Guardian Signature Date

LESLIE CLINIC, P.A. - PATIENT INFORMATION

PATIENT'S COMPLETE NAME (First, M.I., Last)		SOC.SEC. #		MARITAL STATUS					DATE OF BIRTH	AGE	SEX
				S	M	W	D	SEP			M F
STREET ADDRESS ☐ PERMANENT ☐ TEMPORARY		CITY AND STATE							ZIP CODE	HOME PHONE #	
PATIENT'S EMPLOYER		OCCUPATION (Indicate if Student)							HOW LONG EMPLOYED	PATIENT CELL PHONE #	
PATIENT'S EMPLOYER'S ADDRESS		CITY AND STATE							ZIP CODE	WORK PHONE #	
HUSBAND'S ☐ OR FATHER'S ☐ COMPLETE NAME		SOC. SEC. #		DATE OF BIRTH						HOME PHONE #	
HIS EMPLOYER		HIS OCCUPATION (Indicate if Student)							HOW LONG EMPLOYED	HIS CELL PHONE #	
HIS EMPLOYER'S ADDRESS		CITY AND STATE							ZIP CODE	HIS WORK PHONE #	
WIFE'S ☐ OR MOTHER'S ☐ COMPLETE NAME		SOC. SEC. #		DATE OF BIRTH						HOME PHONE #	
HER EMPLOYER		HER OCCUPATION (Indicate if Student)							HOW LONG EMPLOYED	HER CELL PHONE #	
HER EMPLOYER'S ADDRESS		CITY AND STATE							ZIP CODE	HER WORK PHONE #	
PERSON RESPONSIBLE FOR BILL, IF NOT ABOVE		ADDRESS, CITY AND STATE							ZIP CODE	PHONE #	

WHICH PHARMACY DO YOU USE?
LIST ANY ALLERGIES (OR REACTIONS) TO DRUGS OR MEDICATIONS
ARE YOU CURRENTLY UNDER ANY OTHER DOCTOR'S CARE?
PERSON TO CONTACT IN CASE OF EMERGENCY (Name, Address, Home Phone, Business Phone)
LIST MEMBERS OF YOUR IMMEDIATE FAMILY
WHO REFERRED YOU TO THIS CLINIC?

INSURANCE COMPANY NAME		NAME OF PERSON LISTED ON INSURANCE CARD					DATE OF BIRTH
SOC. SEC. #	GROUP #	POLICY # OR I.D. #	RELATIONSHIP OF PATIENT TO INSURED				
			SELF	SPOUSE	CHILD	OTHER	
INSURANCE COMPANY NAME		NAME OF PERSON LISTED ON INSURANCE CARD					DATE OF BIRTH
SOC. SEC. #	GROUP #	POLICY # OR I.D. #	RELATIONSHIP OF PATIENT TO INSURED				
			SELF	SPOUSE	CHILD	OTHER	

ASSIGNMENT / AUTHORIZATION / SIGNATURE / BILLING POLICY

ASSIGNMENT OF BENEFITS: I hereby authorize and request the payment of all insurance benefits be made directly to Leslie Clinic, P.A. for medical services rendered to me or my dependent(s).

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION: I authorize **Leslie Clinic, P.A.** to release to my insurance carrier(s) any information needed to determine benefits payable for medical services rendered to me or my dependent(s). I authorize my insurance carrier(s) to accept a reproduced copy of my signature below for the purposes outlined in this Authorization as if it were my actual signature.

SIGNATURE ON FILE: I agree and acknowledge that my signature on this document authorizes my physician to submit claims for services rendered to my insurance carrier(s) without obtaining my signature on each and every claim to be submitted for me and/or my dependent(s). I authorize the use of this Signature On File on all my insurance claim submissions.

BILLING POLICY: I agree to pay for services rendered to me and/or my dependent(s). I understand that payment in full of my share of the charges is expected at the time services are rendered unless payment arrangements are made in advance. In the event my account or my family member's account is turned over to an outside collection agency, I agree to pay for collection costs, which could total up to 50% of the balance due.

SIGNED: DATE:

SIGNED: DATE:

" LESLIE CLINIC IS IN COMPLIANCE WITH THE TITLES VI AND VII OF THE CIVIL RIGHTS ACT."

PAYMENT POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you.

- Generally, payment for services rendered is due at the time of service, unless other arrangements have been made in advance.
- Self-pay patients are responsible for the entire amount of the bill; patients enrolled in health plans are responsible for any amounts not covered by their insurance.
- *Insurance*. We participate in a number of insurance plans, including Medicare and Medicaid. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with questions you may have regarding your coverage.
- *Co-payments and Deductibles*. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. There will be a $2.00 charge to your account for any co-payment that is not paid on the date of service. If you have not met your deductible you will be asked to make payment in full at the time of service.
- *Non-covered Services*. Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
- *Payment Arrangements*. We are always willing to discuss payment arrangements. Once arrangements have been made, we simply ask you to be as reliable about making your payments as our physicians are about being available to you and your family when you are ill.
- *Proof of Insurance*. All patients must complete our patient information form before establishing care. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the full amount of a claim.
- *Claims Submission*. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Failure to provide information may result in denial of payment of the claim. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
- *Coverage Changes*. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will be billed to you.
- *Nonpayment*. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we will consider you to have terminated your relationship with the physicians of this clinic. We may then refer your account to a collection agency and you and your immediate family members may be discharged from this practice.
- *Returned Checks*. If a check is returned to us unpaid by your bank, we will charge your account a $5.00 non-refundable handling fee. If the check is not paid within 10 working days, we will charge your account a $25.00 non-refundable merchant fee, refer the check to the prosecuting attorney's office, and you and your family members may be discharged from this practice.
- *Discharge Policy*. If you are deemed to have terminated your relationship with this clinic, or if you are discharged from this practice for any reason, your immediate family members may also be discharged. When this occurs, you will be notified by certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physicians will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for reading our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Signature of Spouse Date

"The Leslie Clinic, P.A. is in compliance with Titles VI and VII of the Civil Rights Act."

THE LESLIE CLINIC, P.A.

Section 1. Notices of Privacy Practices for Protected Health Information Acknowledgement:

We are required by law to provide individuals with the Notices of Privacy Practices for Protected Health Information. If you have any objections to this form, please ask to speak with one of our HIPAA Compliance Officers, Kim Hawks, Shirley Breece or Sharon Puhaida, in person or by phone, at 306 N. Chestnut Street, Harrison, Arkansas 72601, (870) 741-8559.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for The Leslie Clinic, P.A.. This Notice describes the types of uses and disclosures of my protected health information (PHI) that might occur in my treatment, payment of my bills, or in the performance of health care operations. This form will be filed in the patient's medical record.

Printed Name	Signature	Date
Legal Representative	Description of Authority	Date

Section 2. Authorized Personal Representative(s):

Authorized Personal Representatives are persons to whom the clinic may release Protected Health Information regarding ongoing treatment, payment and Healthcare operations (for example: appointment times, prescriptions, details about treatment or billing information). Some examples of an Authorized Personal Representative are: a spouse, an adult child, a grandparent, a non-custodial parent or anyone else you feel might need to be informed about the patient. Please fill out the following to designate your Authorized personal Representative(s) or to designate additional Authorized Personal Representatives for your dependents(s). Protected Health Information will not be released to any family members without your authorization, unless required or authorized by law.

I authorize the physicians and staff of The Leslie Clinic, P.A. to recognize the following persons(s) as the Authorized Personal Representative(s) for myself and for my dependent(s):

Patient Name(s)	Authorized Personal Representative(s)	Relationship To Patient	Information Which May Be Disclosed
			☐ All ☐ Limited to _____
			☐ All ☐ Limited to _____
			☐ All ☐ Limited to _____
			☐ All ☐ Limited to _____
			☐ All ☐ Limited to _____
			☐ All ☐ Limited to _____

Printed Name	Signature	Date

Office Use Only

An attempt was made to obtain the patient's or legal representative's signature on this Acknowledgement but did not because:

☐ It was emergency treatment ☐ Inability to communicate with patient ☐ Patient refused to sign

☐ Patient was unable to sign Reason: _____

☐ Other: _____

_____

Signature of Healthcare Representative