NARCOTIC PAIN MEDICATIONS

DUE TO THE NATURE OF THE FOLLOWING MEDICATIONS THE PROVIDERS OF

THE LESLIE CLINIC

WILL NOT BE ACCEPTING PATIENTS WHO TAKE THESE MEDICATIONS:

ATIVAN ** XANAX ** VICODIN

HYDROCODONE ** OXYCODONE

LORTAB ** METHADONE ** NORCO

SOMA ** DIET PILLS ** SLEEPING PILLS

THE LESLIE CLINIC, PA 2017

Patient Questionnaire

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

Name: _____ Date of Birth: _____

Address: _____ Male ☐ Female ☐

_____ Primary Language: _____

_____ Ethnicity: _____

In Case of Emergency, Notify: _____

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.

Allergy	Reaction Experienced

Medications: INCLUDE ALL YOU HAVE TAKEN IN THE PAST 12 MONTHS!

Please list any prescription medications, over the counter medications, vitamins, herbs or nutritional supplements that you ***HAVE TAKEN IN THE PAST 12 MONTHS.***

Please include the dosage amount and the prescribing physician.

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

Patient Questionnaire

Medical / Surgical History: Please list an illness/Operations/Injuries and the dates on which they occurred.

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? _____

_____

02/06/17

The Leslie Clinic, PA

This form gives us permission to check your prescription history for the Past Year.

We are looking to see if you have taken a controlled substance within the past 12 months.

Please list all medications for the Past 12 Months, if you are taking them or not. On the Patient Questionnaire.

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

BY SIGNING BELOW I GIVE PREMISSION, WITHOUT LIMITATION OR EXCLUSION, FOR THE LESLIE CLINIC 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 MECICATION HISTORY FROM MULTIPLE MEDICAL PROVIDERS AND PHARMACY BENEFIT MANAGERS MAY BE VIEWABLE AND THAT GRANTING THIS PERMISSION WILL ALLOW MY PROVIDERSS TO BETTER COORDINATE MY CARE AND TO MAXIMIZE THE EFFECTIVENESS AND SAFETY OF MY TREATMENT PLAN.

I CERTIFY THAT I HAVE **READ AND UNDERSTAND** THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE ACCESS.

******SIGNATURE OF PATIENT OR REPRESENTATIVE:*** _____

DATE_____ TIME_____

*****MUST BE SIGNED**

LESLIE CLINIC, P.A. - PATIENT INFORMATION

PATIENT'S COMPLETE NAME (First, M.I., Last)	SOC SEC. #	MARITAL STATUS (S / M / W / D / SEP)	DATE OF BIRTH	AGE	SEX (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 the 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."

The Leslie Clinic, PA - Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care.

1. **Insurance.** We participate in most insurance plans, including Medicare. 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 any questions you may have regarding your coverage.

2. **Co-payments and deductibles**. All co-payments and deductibles must be **paid at the time of service**. This arrangement is part of your contract with your insurance company.

3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. 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 balance of a claim.**

5. **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. 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.

6. **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

7. **Nonpayment**. If your account is **over 60 days past due**, you will receive a letter stating that you have 10 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. You and your immediate family members will be discharged from this practice.

8. **Missed appointments**. Please help us to serve you better by keeping your regularly scheduled appointment. **Three or more No Show Appointments will cause immediate dismissal**.

9. **Discharge Policy**. This practice can discharge you for any reason. Your immediate family members may also be discharged. For 30 days our providers will only be available to you on an emergency basis only.

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

Signature of patient or responsible party Date

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, 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

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

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