Clarksville Medical Group
Healthcare for Life

New Patient Registration Form

Effective April 25, 2022

☐ **John C. Dunham, MD** ☐ **Mary JaNell Burch, MD** ☐ **Sarah Woodruff, MD**

Last Name:	**First Name:**	**Middle Initial:**
Physical Address:	**City, State, Zip:**	
Mailing Address:	**City, State, Zip:**	
Home Phone:	**Cell Phone:**	**Work Phone:**
Email Address:		
Social Security No.:	**Date of Birth:**	**Sex:** ☐ **Male** ☐ **Female**

Marital Status:	**Language:**	**Ethnicity:**	**Race:**
☐ **Single**	☐ **English**	☐ **Not Hispanic or Latino**	☐ **African American**
☐ **Married**	☐ **Spanish**	☐ **Hispanic or Latino**	☐ **Asian**
☐ **Divorced**	☐ **Karen**		☐ **American Indian**
☐ **Widow / Widower**	☐ **Other:**		☐ **Caucasian**
☐ **Separated**			☐ **Other**

Pharmacy:
Guarantor Name (If not the Patient):
*** Relationship of Guarantor to Patient:** ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other (please explain):** * *Must have Legal Guardianship papers if Guarantor is not a parent.*

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Insurance:	**Insurance:**
Member ID:	**Member ID:**
Subscriber Name (if not patient)**:**	**Subscriber Name** (if not patient)**:**
Subscriber Date of Birth:	**Subscriber Date of Birth:**
Relationship to Patient:	**Relationship to Patient:**

ASSIGNMENT AND RELEASE:

- I hereby assign my insurance benefits to be paid directly to the physician.
- I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
- I authorize the physician to release any medical information required to process this claim.
- I authorize my provider's office to contact me by telephone to remind me of my appointments.
- A $25.00 fee for no shows may apply.

Signed: _____ **Date:**_____

Clarksville Medical Group
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List of Current Medications

Effective April 25, 2022

	MEDICATION NAME	INSTRUCTIONS
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

Clarksville Medical Group
Healthcare for Life

Consent to Disclose Private Health Information (PHI)

Effective April 25, 2022

Patient Name (please print)**:**	**Date of Birth:**

Permitted Uses / Disclosures

1.	May we contact you or person(s) listed below with appointment reminders or rescheduling, information about treatment alternatives, or information about other health-related benefits or services that may be of interest to you?	☐ YES	☐ NO
2.	May we use / disclose your protected health information (PHI) to notify or assist in notifying the person(s) listed below about your location, general condition, or death?	☐ YES	☐ NO
3.	Communication with Family – Using our best judgment, may we disclose to the person(s) listed below your protected health information relevant to that person's involvement in your care, in payment for such care, or in the case of emergency?	☐ YES	☐ NO
4.	May we use / disclose your protected health information to assist in disaster relief efforts relevant to you and / or your family?	☐ YES	☐ NO
5.	May we use / disclose your protected health information to the person(s) listed below after your death for life insurance / legal issues?	☐ YES	☐ NO

Please list below the family members and / or personal representatives who may have information / access to your records / personal health information (PHI).

Printed Full Name	Date of Birth	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

My signature designates the above-named person(s) as my healthcare representative(s) and gives Clarksville Medical Group, P.A. the authority to release my protected health information (PHI) to them until which time I revoke this authorization.

Patient Signature / Guarantor:_____ Date:_____

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Acknowledgement

Effective April 25, 2022

Please read and initial each statement below:

_____ **Receipt of Notice of Privacy Practices:**

- *I have recieved a copy of Clarksville Medical Group's Notice of Privacy Practices.*

_____ **Medication History Authority**:

- *I give permission for Clarksville Medical Group to collect my medication list and history from my pharmacy.*

_____ **Consent to Call/Text:**

- *I give my permission for Clarksville Medical Group to notify me by phone of any appointments, lab test results, billing phonecalls or texts, or any other concerns.*

By signing this document, I hereby agree with and understand these practices. I give my consent to Clarksville Medical Group, P.A.

Patient Signature / Guarantor:_____ Date:_____

Proof of Insurance and Patient Payment Policy

Effective July 1, 2021

Thank you for choosing Clarksville Medical Group, P.A. (CMG) as your Primary Care Provider (PCP). Since 1973 CMG has provided to our Patients quality and affordable ***Healthcare for Life***™.

Proof of Insurance

All Patients must complete our **Patient Information Form** before seeing their care provider. We must obtain and review copies of the following: ***Current Driver's License, Current Proof of Primary Insurance, Current Proof of Secondary Insurance.*** Failure to provide the correct ***Name, Address, Phone Number, and Current Proof of Insurance*** in a timely manner may cause you to be financially responsible for full payment at time of service.

Patient Payment Policy

1. **Uninsured / Inadequate Proof of Insurance.** If you are uninsured, or not insured by a plan we are affiliated with, or do not have current proof of insurance, ***payment in full is expected at each visit.***
2. **Insured.** Each patient is responsible for knowing their insurance benefits. Please make sure your insurance correctly states the name of your Primary Care Provider. At check-n you must provide current proof of insurance. CMG participates in most insurance plans, including Medicare.
3. **Insured Co-Payments and Deductibles.** All Co-Payments and Deductibles must be paid at time of service. These are normally collected at time of Check-In but may be collected at time of Check-Out. All Insurance Companies require that we do this, and failure on our part to collect Co-Payments and Deductibles at time of service can be considered fraud. Co-Payments and Deductibles may be paid via cash, check, credit cards and money orders.
4. **Non-Covered Services. IMPORTANT** – Please understand that some, and possibly all services you receive may not be covered by your insurance or may not be considered reasonable or necessary by Medicare or other Insurers. You must pay for these services in full at time of service. ***It is your responsibility to know your insurance benefits.***
5. **Claims Submission.** We will submit your claims and assist you in any way that we reasonable 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(s). The balance of your claim is your responsibility, regardless of whether or not your Insurance Company pays for 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 you change insurance, PLEASE notify us before your next visit so we can update our records to help you receive your maximum benefits. If your Insurance Company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment.** All balances are required to be paid in full within a twelve (12) month time frame of the date of service. Payment plans are available. Payments must be made monthly until fully paid off. If a balance remains unpaid, we will refer your account to a collection agency, and you and your immediate family members may be discharged from this Practice.

Please acknowledge receipt and understanding of these policies as a condition of your care by signing in the space provided below. A copy will be provided to you upon request.

_____ _____

Signature of Patient or Responsible Party **Date**

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Healthcare for Life

Patient Appointment No-Show and Rescheduling Policy

Effective July 1, 2021

Thank you for choosing Clarksville Medical Group, P.A. (CMG) as your Primary Care Provider (PCP). Since 1973 CMG has provided to our Patients quality and affordable ***Healthcare for Life***™.

We work hard to see our Patients on time. If you are unable to keep your appointment, **PLEASE** call us as far in advance as possible so we can offer the time reserved for you to another Patient who needs our care.

Patient Appointment No-Show and Rescheduling Policy

8. **Appointment Arrival.** Please arrive for your appointment ***15 minutes early*** to allow time to be checked in. When you run late our Providers run behind. When we start the morning behind, it trickles through the day and our Patients must wait longer for their afternoon appointments. ***Please arrive 15 minutes early.***
9. **No-Show Status.** If you are ***more than 15 minutes late you will be considered a "No-Show" and your appointment WILL BE RESCHEDULED***. This is necessary to provide care in a timely manner to our Patients that arrive and check-in 15 minutes before their appointment.
10. **Rescheduling Appointments.** If you must cancel or reschedule your appointment, ***we require 24 working hour notice***. To reschedule:

    1) **Call us at 479-754-8384 to speak with a Patient Services Representative or leave a message.**
    2) **Send us a message through the Athena Portal.**
    3) **Send us an email to appointments@cmgclinic.com.**

11. **No-Show Fee.** A **Twenty-Five Dollar ($25.00) No-Show Fee** will be billed to your account if you cancel your appointment with less than 24 working hour notice. **This fee IS NOT covered by your insurance. You are responsible for this fee and will bear the complete financial responsibility.** It only takes a few minutes to call, leave a message, send a message through the Portal, or send an email. ***Your communication is important to your Provider and the other Patients.***
12. **Dismissal From Practice – Current Patients.** Two (2) missed appointments within a three-month period without 24 working hour notification may cause dismissal from practice.
13. **Dismissal From Practice – New Patients.** One missed appointment within a two-month period without 24 working hour notification may cause dismissal from practice.

Patients who schedule clinic appointments and fail to keep them have a negative impact on patient care, productivity, and patient education. Our No-Show Policy is intended to improve both the health and quality of life for our patients by increasing access to care.

Please acknowledge receipt and understanding of this policy as a condition of your care by signing in the space provided below. A copy will be provided to you upon request.

_____ _____

Signature of Patient or Responsible Party **Date**

Clarksville Medical Group, P.A.
601 McKennon Street
Clarksville, AR 72830
Phone: 479-754-8384
Fax: 479-754-7141

Medical Records Release Request Form

Effective April 25, 2022

☐ **John C. Dunham, MD** ☐ **Mary JaNell Burch, MD** ☐ **Sarah Woodruff, MD**

☐ **Jess E. Jordan, APRN** ☐ **Kayla Metz, APRN**

Last Name:	**First Name:**	**Middle Initial:**
Physical Address:	**City, State, Zip:**	
Home Phone:	**Cell Phone:**	**Work Phone:**
Social Security No.:		**Date of Birth:**

The *Medical Records Release Request Form* is **a single use authorization form** where the Patient gives permission to Clarksville Medical Group, P.A. (CMG) **to proceed with the disclosure of Protected Health Information (PHI) using only one (1) of the two (2) options** described below.

Option 1 - RELEASE	**Option 2 - OBTAIN**
☐ I hereby authorize Clarksville Medical Group, P.A. to **RELEASE** my Protected Health Information (PHI) to the following Physician / Facility.	☐ I hereby authorize Clarksville Medical Group, P.A. to **OBTAIN** my Protected Health Information (PHI) from the following Physician / Facility.
Physician / Facility:	**Physician / Facility:**
Address:	**Address:**
City/State/Zip:	**City/State/Zip:**
Phone No.:	**Phone No.:**
Fax No.:	**Fax No.:**

Send the following records:

☐ **Most Recent Two (2) Years of Records**	☐ **EGD / Colonoscopy Reports**	☐ **Six (6) Months of Labs**
☐ **Mammograms**	☐ **CT / MRI**	☐ **Two (2) Years of Cardiac History**
☐ **Other:**		
Purpose of Disclosure: ☐ **Continuation of Care** ☐ **Insurance** ☐ **Attorney** ☐ **Personal**		

This authorization will expire: Six (6) months from the date of signature. I understand that my information may not be protected from re-disclosure by the requester of the information; however, Clarksville Medical Group, P.A. will use this information only as authorized by me or otherwise required by or allowed by law. I understand that if my records contain information relating to venereal diseases, hepatitis, HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I have the right to revoke this authorization by written notification to the health care provider to with this authorization is submitted. This provider must comply except to the extent the provider had already acted in reliance upon this authorization.

Signature:	**Relationship to Patient*:**
Printed Name:	**Date:**

Power of Attorney or Legal Guardianship papers must be on file for someone other than the patient to sign if the patient is over the age of 18 or if you are not the parent of the child / minor patient.

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Patient Agenda / History Questionnaire

Effective April 25, 2022

Patient Name (please print)**:**	**Date of Birth:**

What concerns and symptoms are you wanting to be seen for today?

Please list medicine or food allergies:

YOUR PAST MEDICAL HISTORY (Please mark all that apply)

MEDICAL HISTORY	YES	MEDICAL HISTORY	YES	MEDICAL HISTORY	YES
Measles		High Blood Pressure		Heart Disease / Attack	
Mumps		Tuberculosis		Infection	
Chicken Pox		Cancer		Stomach Ulcer	
Whooping Cough		Hypoglycemia Anemia		Varicose Veins	
Rheumatic Fever		Hepatitis A/B/C		Stroke / Paralysis	
Pleurisy		Mastitis		Hemorrhoids	
Pneumonia		Migraine – Chronic		(Low Blood Sugar)	
Gallstones		Ear Infection – Chronic		Blood Transfusions	
Kidney Stone		Strep Throat - Chronic		Anorexia / Bulimia	
Infection		Tonsillitis		Brain Disorders	
Prostate Disease		Thyroid		Anxiety	
Arthritis		Bronchitis		Depression	
Endocrine Problems		Insomnia		Glaucoma / Vision Problems	
Circulation Problems		MS / ALS		Sleep Apnea	
Parkinson's Disease		Asthma		Hearing Loss	
COPD		Weight Gain / Loss		Osteoporosis	
Migraine		Sciatica		IBS	
Scoliosis		Cachexia / Wasting Syndrome		Colitis	
Auto-immune Disorder		Crohn's Disease		Disc Injury	
Epilepsy / Seizures / Spasms		Shortness of Breath		Schizophrenia	
Alzheimer's Disease		Emphysema			
Parkinson's Disease		Kidney Diabetes			

Other Medical History:

Do you have difficulty with daily activities where you substantially limited (i.e. pain, weakness, impaired strength or ability) by any of your medical conditions? If so, please describe the activities you have difficulty with.

Patient Agenda / History Questionnaire

Effective April 25, 2022

SURGICAL HISTORY (Please mark all that apply)					
SURGICAL HISTORY	**YES**	**SURGICAL HISTORY**	**YES**	**SURGICAL HISTORY**	**YES**
Tonsillectomy		Colonoscopy		Skin Tumor	
Adenoidectomy		Hysterectomy		EGD	
Gallbladder		Hernia Repair		Vasectomy	
Breast Biopsy Removal		Hemorrhoid Removal		Circumcision	
Other Surgical History:					

OTHER PERSONAL HEALTH HISTORY				
What is your occupation?			Do you live alone?	☐ YES ☐ NO
Do you smoke tobacco?	☐ YES	☐ NO	If so, how many packs a day?	
If you smoked in the past when did you quit?			How many years did you smoke?	
If you do not smoke, are you exposed to secondhand smoke daily?				☐ YES ☐ NO
Do you chew tobacco?	☐ YES	☐ NO	If so, how often and how much?	
Do you vape?	☐ YES	☐ NO	If so, how often and level of nicotine?	
Do you drink alcohol?	☐ YES	☐ NO	If so, how many drinks per week?	
Are you planning on becoming pregnant?				☐ YES ☐ NO

OB-GYN (Females Only)		
Total Pregnancies:	Total Live Births:	Total Miscarriages:
Onset of Menstrual Periods (Age):		Age of Menopause:
Any child birthed over nine pounds (9 lbs)?		☐ YES ☐ NO
Last Pap Smear:		Last Mammogram:

FAMILY HISTORY

Indicate if any of your blood relatives (Aunts, Uncles, Grandparents, Children, Parents, etc.) have ever had the following.

CONDITION	YES	RELATIVE	CONDITION	YES	RELATIVE
Diabetes			Heart Attack		
Cancer			Lung Disease		
Tuberculosis			Strokes		
High Blood Pressure			Blood Disease		
Arthritis			Thyroid Disease		
Kidney Disease			Hepatitis A/B/C		
Epilepsy (Fits)			Other Infectious Diseases		
Heart Disease					

Specialty doctors you are currently seeing (Cardiologist, Gynecologist, Gastroenterologist, etc.). Please provide name and specialty.

I attest that the information that I have provided is true and correct to the best of my knowledge.

Signature:	**Date:**