TIMM REECE, MD
FAMILY MEDICINE
OF WHITE HALL, P.A.

7245 Sheridan Road, White Hall, AR 71602
2302 W. 28th Avenue, Suite A, Pine Bluff, AR 71603
1600B N. Lincoin Ave, Star City, AR 71667
Phone (870) 850-8055 Fax (870) 850-8056 Email questions@familymedwh.com

PLEASE CHECK THE BOX THAT APPLIES TO YOU

☐ I want to establish care and make Family Medicine of White Hall my new primary care clinic.

☐ I want to be seen for walk-in services only and prefer to keep my current primary care physician.

Patient Name: _____ DOB: _____

Patient/Responsible Party Signature: _____

Today's Date: _____

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NEW PATIENT APPLICATION
ENTIRE FORM MUST BE COMPLETED

The following form will provide our office the information needed to accept you as a new patient. We currently have some restrictions when considering NEW patients. We will not be able to see you if:

- You are requesting treatment for a work related injury;
- You are requesting treatment for a motor vehicle accident;
- You are taking chronic pain medication.

If you are currently taking chronic pain medication and are under the care of a pain specialist, our office may make an exception in your case. If an exception is made for you, understand we **WILL NOT** refill your chronic pain medication or assume responsibility for pain medication you are already taking.

Please sign on the line below to indicate you have read and understand these conditions:

_____
PATIENT SIGNATURE OR GUARDIAN (IF MINOR)

WE LOOK FORWARD TO CARING FOR YOU AND YOUR FAMILY.

CHART NUMBER_____(OFFICE USE ONLY) Date_____

PERSONAL INFORMATION

PATIENT FULL NAME_____ DATE OF BIRTH _____/_____/_____

ADDRESS_____ SOCIAL SECURITY # _____-_____-_____

CIRCLE

City, State, Zip _____ **GENDER: Male / Female**

RACE: Caucasian / Black / Hispanic/

Other

PLACE OF EMPLOYMENT_____ **ETHNICITY: Hispanic/**

Other

EMAIL _____ **MARITAL STATUS: S M D W**

HOME #_____ CELL #_____ WORK #_____

PARENT (IF PATIENT IS A MINOR) OR SPOUSE INFORMATION

PARENT/SPOUSE NAME _____ DATE OF BIRTH _____

ADDRESS _____ SOCIAL SECURITY#_____

Home # _____

City, State, Zip_____ Cell # _____

Work # _____

PLACE OF EMPLOYMENT _____ Email _____

EMERGENCY CONTACT

NAME_____ RELATIONSHIP TO PATIENT_____

ADDRESS _____

HOME#_____ WORK#_____ CELL#_____

INSURANCE

PRIMARY INSURANCE NAME_____ ID NUMBER_____

SECONDARY INSURANCE NAME_____ ID NUMBER_____

OTHER INFORMATION

PRIOR/CURRENT PHYSICIAN_____ LAST SEEN_____

PLEASE LIST ALL MEDICATION, PRESCRIBED AND/OR OVER THE COUNTER, YOU ARE CURRENTLY TAKING:

_____

_____

ARE YOU TAKING CHRONIC PAIN MEDICATION _____

PLEASE LIST YOUR MEDICAL CONDITIONS, PROBLEMS, OR DIAGNOSIS:

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATION, LATEX, FOODS, ETC. _____

IF SO, PLEASE LIST _____

Consent to Obtain Medication History from Pharmacies through e-Prescribing:

I hereby give my consent to Family Medicine of White Hall, P.A., including its licensed practitioners and employees, to access, use and disclose my protected health information to any pharmacies I currently use or will use in the future for the purpose of transmitting prescriptions to them for my treatment. I consent to the disclosure of my prescription medication information by any provider, mental health provider, pharmacy, insurer or prescription benefits manager, specifically including any state or federal health program to Family Medicine of White Hall, P.A. and pharmacies for the purpose of my treatment. My consent includes the re-disclosure of protected health information maintained by a drug or alcohol treatment program.

_____ _____ _____

Signature of Patient or Legal Representative ***Date*** ***Relationship to Patient***

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please pick up a copy of our Notice of Privacy Practices from the front desk. If you have any questions regarding the information in Family Medicine of White Hall, P.A.'s Notice of Privacy Practices, please do not hesitate to contact a clinic representative or the Privacy Officer as indicated on the Notice.

_____ _____ _____

Signature of Patient or Legal Representative ***Date*** ***Relationship to Patient***

TIMM REECE, MD
FAMILY MEDICINE
OF WHITE HALL, P.A.

FINANCIAL POLICY

Thank you for choosing Family Medicine of White Hall as your healthcare provider. We are committed to providing you with the best possible care. Following a recent review of our practice, we have revised our financial policy. It is important that patients read and understand the financial policy and billing procedures of the clinic.

As a courtesy to our patients, we will submit insurance claims to your insurance company directly. However, you are responsible for these charges. Your insurance policy is a contract between your insurance company and you. We are not a part of that contract. Our professional services are rendered to you, not your insurance company; therefore, payment for treatment is your responsibility. **If you are covered by insurance, your co-payment, deductible and non-covered charges are expected at the time of service along with any past due balance. You will be required to pay your authorized portion of the bill at the time services are rendered unless payment arrangements have been approved in advance by our staff.** We accept cash, check, money order, MasterCard, Visa, and Discover.

1. I hereby give consent for Family Medicine of White Hall, P.A., to provide medical treatment.
2. I authorize this office to release or receive any information necessary to expedite insurance claims.
3. I hereby authorize this office to bill my insurance company directly for their services.
4. If I am not covered by medical insurance I understand **full payment is due at the time of each visit and/or service**.
5. I authorize payment directly to this clinic of any insurance benefits otherwise payable to me.
6. In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to Family Medicine of White Hall for which these fees are payable.
7. I understand certain routine services are deemed necessary by my physician for the maintenance of good health and may not be covered or deemed medically necessary by my insurance carrier and that I will be expected to pay for these services in full at the time of service, or when billed, if they are denied or not paid by my insurance carrier for any reason.
8. I understand that for all services rendered to minors, the adult accompanying the minor is responsible for full payment.
9. I understand that I am directly and fully responsible to this clinic for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgment or insurance payment by which I eventually recover said fee.
10. I realize that if my insurance company fails to pay my balance in full, or there is no payment within 60 days, it is my responsibility to pay any and all charges incurred by me at Family Medicine of White Hall.
11. I understand and agree that unresolved balances may be placed with an outside collection agency. These unresolved balances may also be subject to finance charges, attorney fees and collection agency fees. If your account has been placed with a collection agency, you have three (3) options when making an appointment to see a physician: $100 prepayment (includes co-pay) for today's services, reschedule when you are able to make the prepayment, or see a representative regarding your account.
12. I understand there will be a $30.00 charge on all returned checks. Returned check amount and fee will need to be paid by cash or credit card.
13. I understand that should I not bring my co-pay, deductible or balance due at the time of my appointment, I may be required to reschedule my appointment until payment is received. Should I be seen by the physician without paying my co-pay, deductible, or balance due, I may be charged a $25.00 statement fee. If I am unable or unwilling to meet these financial requirements and my medical conditions require immediate attention, I understand that I may go to the nearest emergency room.

If you have any questions about our financial policy or your insurance reimbursement, please feel free to discuss them with any accounting staff member.

I have read and understand my financial responsibilities under this policy.

Patient Name: _____ DOB: _____

Patient/Responsible Party Signature: _____ Date: _____

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OF WHITE HALL, P.A.

MEDICATION POLICY

Please be advised that if you are on any of the following medications or on a pain contract or pain management from another physician, you must continue to receive your medication from that physician. **Our office WILL NOT routinely prescribe these medications.** We want to be upfront with you in regards to this so that we will be helping to eliminate any confusion. There may be other medications not listed below that may also be included in this policy. This will be at the discretion of Dr. Timm Reece.

If you have any questions, please feel free to ask.

BRAND NAME	GENERIC NAME
Xanex, Valium, Ativan	Alprozolam, Diazepam, Lorazepam
Anexsia, Bencap HC, Ceta-Plus, Co-Gesic, Dolacet, Dolagesic, Dolorex Forte, Duocet, Hy-Phen, Hydrocet, Hydrogesic, Lorcet, Lorcet HD, Lorcet Plus, Lortab, Margesic-H, Norco, Panacet, Polygesic, Stagesic, T-Gesic, Ugesic, Vanacet, Vicodin, Vicodin ES, Vicodin HP, Zydone	Hydrocodone
M-Oxy, OxyContin, OxyFast, OxyIR, Percolone, Roxicodone	Oxycodone
Endocet, Percocet, Roxicet, Roxilox, Tylox	Percocet
Mepergan	Mepergan
Astramorph PF, DepoDur, Duramorph, Infumorph, Kadian, Morphesian, MS Contin, MSIR, Oramorph, Roxanol, Roxanol 100	Morphine
Adipex (WEIGHT LOSS MEDICATION) Lonamin, Adipex-P	Phentermine Hydrochloride
Rela, Soma	Carisoprodol

Upon signing this acknowledgment of this policy, you are accepting this policy set forth by this office.

_____ _____

SIGNATURE PRINTED NAME

_____ _____

RELATIONSHIP TO PATIENT DATE

_____

WITNESS

Notice updated and effective January 1, 2021

FAMILY MEDICINE OF WHITE HALL, P.A. 7245 Sheridan Road, White Hall, AR 72602 (870) 850-8055

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR PROTECTED HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in regards to your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT: Privacy Officer Phone (870) 850-8055

Family Medicine of White Hall, P.A.
7245 Sheridan Road
White Hall, AR 71602

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your PHI:

1. Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

* maintaining vital records, such as births and deaths
* reporting child abuse or neglect
* preventing or controlling disease, injury or disability
* notifying a person regarding potential exposure to a communicable disease
* notifying a person regarding a potential risk for spreading or contracting a disease or condition
* reporting reactions to drugs or problems with products or devices
* notifying individuals if a product or device they may be using has been recalled
* notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
* notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

* Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
* Concerning a death we believe has resulted from criminal conduct
* Regarding criminal conduct at our offices
* In response to a warrant, summons, court order, subpoena or similar legal process
* To identify/locate a suspect, material witness, fugitive or missing person
* In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when Internal or Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs.

13. Marketing and Disclosures That Constitute a Sale of PHI. Authorization from the patient is required for uses and disclosures of PHI for marketing purposes or disclosures that constitute the sale of PHI.

14. Other Uses and Disclosures Not Described in This Notice. Other uses and disclosures not described in this notice will be made only with authorization from the individual.

E. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the Privacy Officer specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions.

1) You have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Privacy Officer. Your request must describe in a clear and concise fashion:

a) the information you wish restricted;

b) whether you are requesting to limit our practice's use, disclosure or both; and

c) to whom you want the limits to apply.

2) You have the right to request a restriction in our use or disclosure of your PHI to a health plan if:

a) The disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and

b) The PHI pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, **has paid the covered entity in full**.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Privacy Officer in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. Examples include when the doctor shares information with the nurse or the billing department uses your information to file your insurance claim. Also, we are not required to document disclosures made pursuant to an authorization signed by you. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the Privacy Officer.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. For questions related to filing a complaint, contact our office and ask for the Privacy Officer. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

9. Rights Regarding Breach Notification. You have the right to receive notification of breaches of your unsecured PHI. Our practice will notify you of breaches of your unsecured PHI in accordance with the requirements of the HIPAA Privacy Rule, the HITECH Act, and the Omnibus Rule.

If you have any questions regarding this notice or our health information privacy policies, please contact the Privacy Officer.