MID-DELTA HEALTH SYSTEMS, INC.

Registration Form

Please select your preference of Primary Care Provider (Circle One)

Location A: Clarendon			Location B: DeWitt
Dr. Christopher Hopkinson, MD	Dr. Jennifer Kelly, MD	Dr. Thomas Patten, DDS	Dr. Wallace Tracy, MD
Dr. Curtis Schalchlin, MD	Nancy Hornsby, APN	Haley Ligon, APN	Ashley Loftis, PA

Thank you for choosing us! As a Federally Qualified Health Center, and in order to better serve you, we request you provide us with the following information.

Patient Name:_____ SSN:_____ Date of Birth:_____
Mailing Address:_____ City:_____ State:_____ Zip:_____
Home Phone:_____ Cell:_____ Email:_____
Please only provide your email address IF you authorize us to send you appointment reminders to your email.
Physical Address:_____ Marital Status: Single___Married___Divorced___Widowed_____
Gender: Male_____ Female_____ Pharmacy you prefer to use:_____
Is Mid-Delta Health Systems your Primary Care Provider? *Yes/No* If no, who is your PCP?_____

RESPONSIBLE PARTY – IF DIFFERENT FROM PATIENT

Name of person responsible for this account:_____Relationship to Patient:_____
Address:_____ Phone:_____ SSN:_____ Date of Birth:_____

EMPLOYMENT/STUDENT INFORMATION

Employer/School Name:_____ Work Phone Number:_____
Employer Address:_____ City:_____ State:_____ Zip:_____
Employment/Student Status: Full Time____ Part Time____ Self Employed____ Unemployed____ Retired____

COMPLETE IF PATIENT IS 0-17 YEARS OF AGE

Parent/Legal Guardian:_____
Date of Birth:_____ Phone:_____
Address:_____
_____
Work Phone:_____

Parent/Legal Guardian:_____
Date of Birth:_____ Phone:_____
Address:_____
_____
Work Phone:_____

EMERGENCY CONTACT/RELEASE OF INFORMATION

You may discuss my medical needs or exchange information with the following: (Please list your Primary Contact first)

Name:_____ Relationship:_____ Phone:_____
Name:_____ Relationship:_____ Phone:_____
Name:_____ Relationship:_____ Phone:_____

☐ **I do not want information released to anyone, including my spouse and/or other household members.**

PREFERRED METHOD OF CONTACT

How would you like us to reach you: (Check all that apply) Phone__ Text__ Email__ Language: English____ Spanish____
Best time to contact you: Morning____ Afternoon____ Evening____
Which reminders would you like to receive: (Check all the apply) Appointment Reminders___ Lab Results for Portal____
Health Maintenance____ Prescription Confirmation____ General Notifications____

INSURANCE INFORMATION - PLEASE GIVE YOUR CARD TO THE RECEPTIONIST

Primary Insurance:
Insurance Company:_____ Patient ID Number:_____
Name of Primary Insured/Cardholder:_____ Relationship to Patient:_____
Birth Date of Primary Insured:_____ SSN of Primary Insured:_____ Group Number:_____
Secondary Insurance:
Insurance Company:_____ Patient ID Number:_____
Name of Primary Insured/Cardholder:_____ Relationship to Patient:_____
Birth Date of Primary Insured:_____ SSN of Primary Insured:_____ Group Number:_____

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ADDITIONAL INFORMATION

Race: (Circle One) *American Indian/Alaskan Native Asian Black/African American White/Caucasian Unreported/Refused to Report*
Ethnicity: (Circle One) *Hispanic Non-Hispanic*
Primary Language_____ Do you need a translator: Yes__ No__ Limited English Proficiency: Yes__ No__
Veteran: Yes___ No___ Seasonal Worker: Yes___ No___ Migrant Worker: Yes___ No___ Homeless: Yes___ No___
Homeless Status: Unknown___ Street___ Doubling Up___ Transitional Housing___ Homeless Shelter___ Other___
Live in Government Housing: Yes___ No___
Sexual Orientation: (Circle One) *Straight/Heterosexual Lesbian/Gay/Homosexual Bisexual Something else I don't know I choose not to disclose*
Gender Identity:(Circle One) *Male Female Transgender male/Female-to-male Transgender Female/Male-to-Female Other I choose not to disclose*

ACCIDENT/INJURY INFORMATION – IF APPLICABLE

Insurance Company:_____ Claim Number:_____
Contact/Adjuster Name:_____ Phone Number:_____
Address:_____ City:_____ State:_____ Zip:_____
Date of Injury:_____ Injury at Work: Yes_____ No_____

CONSENT AND ACKNOWLEDGEMENT

CONSENT: The information on this form is true to the best of my knowledge. I voluntarily consent to out-patient care at Mid-Delta Health Systems which may include diagnostic procedures, examinations, and/or treatment by MDHS's providers and/or other staff of the clinic.

RELEASE OF INFORMATION: I authorize Mid-Delta Health Systems to release medical information to third party insurance carriers for the purpose of filing claims, and to release or obtain medical information to/from providers of medical care and the Health Department for the purpose of continuity of care. I authorize payment of medical benefits by my insurance to Mid-Delta Health Systems. I consent for those listed on this form to receive any and all information regarding my healthcare, personal observations and concerns, treatment plans, and prognosis.

PRESCRIPTION HISTORY CONSENT: This facility participates in the Prescription Drug Monitoring Program. Clinicians in this office will not prescribe narcotics, benzodiazepines, or controlled medications for chronic use. I authorize Mid-Delta Health Systems to obtain and review my prescription history from pharmacies, other providers, and other third party entities such as insurance companies.

TRAINING FACILITY: I understand that occasionally health care students may be working with my provider. I give consent to have a health care student observe or participate in my care while under the supervision of my provider. I understand that these health care students are under the same confidentiality policies as my provider. I acknowledge that I have the option of declining the consent.

PATIENT BILL OF RIGHTS/PRIVACY NOTICE: If I want one, I have been given a copy of Mid-Delta Health Systems Patient's Rights and Privacy Notice.

EFFECTIVE PERIOD: I understand this consent/authorization will be valid and remain in effect as long as I attend the clinic or until I revoke this authorization in writing.

Medicaid/ARKids: I understand that if I have Medicaid, this facility must be designated as my Primary Care Physician. If Mid-Delta Health Systems is not my PCP, I acknowledge that I must obtain a referral for services from my PCP or the full amount of services will be due at the time of visit. I understand I am responsible for ANY services not covered by Medicaid or ARKids.

Medicare: I understand that I will be responsible for any service or lab not covered by my Medicare or Medicare replacement plan.

Sliding Fee Scale/Self-Pay: I understand that Mid-Delta Health Systems offers reduced fees on a sliding fee scale based on household income. If I wish to apply for the sliding fee scale, I will fill out the provided form and return my proof of income within 48 hours of visit. If I qualify for reduced fees, I understand that I will be asked to pay an initial fee of $15 for medical or $30 for dental at check in. Any remaining charges will be collected at check out. If I do not have insurance and do not qualify for the sliding fee scale, I will be asked to pay a set fee of $15 for medical or $30 for dental at check-in and additional charges at check-out.

IF YOU ARE UNABLE TO PAY ANY OF THE ABOVE FEES AT THE TIME OF YOUR VISIT YOU MAY BE RESCHEDULED.

_____

Signature of Patient (or Parent/Legal Guardian) Date

MID-DELTA HEALTH SYSTEMS, INC.

CONSENT FOR TELEHEALTH SERVICES

Mid-Delta Health Systems, Inc., 245 Madison Street, Clarendon, AR 72029, 800.244.3602

Patient's Name: _____ Date:_____

1. I understand that my health care provider wishes to engage in a telehealth visit or series of visits. I understand that these encounters will not be the same as a direct patient/health care provider visit because I will not be in the same room as my health care provider. Instead, we will communicate using two-way simultaneous audio-visual technology ("the technology").

2. I understand that I have the right to refuse to participate in any telehealth encounter at any time or to end it at any point during the encounter. I understand that if I do not wish to participate in a telehealth encounter I will need to either make an appointment for an in-person visit with my provider or seek care at the closest emergency department if I believe that my symptoms warrant that level of care. I further understand that my provider may not be able to accommodate an in-person visit and there may be a delay in my care if I choose an in-person visit.

3. I understand that my health care provider can discontinue the telehealth encounter if he or she believes that this technology does not meet the standard of care necessary to address my medical concerns. If that happens, I understand that I will need to either make an appointment for an in-person visit with my provider or seek care at the closest emergency department if I believe that my symptoms warrant that level of care.

4. I understand how the technology will be used to conduct any telehealth encounters with this practice. I also understand that, with this technology, there is a risk of interruption and technical difficulties.

5. I have had the opportunity to ask questions about telehealth encounters and the technology. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language that I understand.

6. I understand that I will be told the identity of everybody who will be in the room with my healthcare provider during any telehealth encounter and that those people will be present only because my health care provider has determined that their presence is necessary to assist in my medical treatment according to the applicable standard of medical care

7. I have been told whether my provider is licensed to provide medical care in the state where I am located. If they are not licensed in the state where I am located, I consent to receive telehealth services anyway because the provider is fully licensed in the state where they are located.

8. I understand that I will be responsible for any copays and coinsurance that apply to my telehealth encounter (s).

9. This consent will remain valid for 1 year from the date of my first telehealth visit.

_____ _____

Signature of Patient or Guardian **Relationship to Patient**

Reason patient is unable to give consent for self: _____

MID-DELTA HEALTH SYSTEMS, INC.

Health History

Have you seen any specialist within the last year? If so, who?

Specialist Name	Location of Specialist

Past Medical History

	Yes	No		Yes	No		Yes	No
Abnormal Mammo	☐	☐	Abnormal Pap	☐	☐	Alcohol Abuse	☐	☐
Acid Reflux	☐	☐	ADHD	☐	☐	Allergies	☐	☐
Anxiety	☐	☐	Arthritis	☐	☐	Bipolar Disorder	☐	☐
Blood Disorder	☐	☐	Cancer-Type_____	☐	☐	Cataracts	☐	☐
CHF Heart Failure	☐	☐	Crohn's Disease	☐	☐	Colon Polyp	☐	☐
COPD	☐	☐	Diabetes	☐	☐	Diverticulitis	☐	☐
Drug/Substance Abuse	☐	☐	DVT Blood Clot	☐	☐	Fibromyalgia	☐	☐
Glaucoma	☐	☐	Gout	☐	☐	Heart Disease	☐	☐
Heart Murmur	☐	☐	Hepatitis	☐	☐	High Blood Pressure	☐	☐
High Cholesterol	☐	☐	HIV	☐	☐	Irritable Bowel Synd.	☐	☐
Kidney Disease	☐	☐	Liver Disease	☐	☐	Lupus	☐	☐
Heart Attack	☐	☐	Prostate Disorder	☐	☐	Renal (Kidney) Failure	☐	☐
Seizure Disorder	☐	☐	Stroke	☐	☐	Thyroid Disorder	☐	☐

Surgeries

Year	Reason	Hospital

Family History (Check all the apply)

			Father's Side		Mother's Side			
	Father	Mother	Grandpa	Grandma	Grandpa	Grandma	Siblings	Children
Alive	☐	☐	☐	☐	☐	☐	☐	☐
Deceased	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Don't Know	☐	☐	☐	☐	☐	☐	☐	☐

Allergies

Are you allergic to any medications? □ **Yes** □ **No**

If yes, please list which medications.

Name of Medication	Reaction

Social History

	Yes	No
1. Have you applied and been denied public housing?	☐	☐
2. Have you applied and been denied food stamps?	☐	☐
3. Are you having problems with your landlord regarding safety?	☐	☐
4. Have you applied and been denied WIC, Medicaid, Disability, Social Security or SSI?	☐	☐

If yes, please list which you were denied:_____

5. Who does your support system consist of? Check all that apply:

□ Mother □ Father □ Child □ Sibling □ Spouse □ Other

6. Who do you live with in your household? Check only one:

□ Alone □ With Parent □ With Spouse □ With Other

7. Do you have a legal guardian or health care proxy (someone who can legally make decisions for you if you are unable)?	☐	☐

If yes, who? _____

8. Do you have a primary care giver (someone who takes care of you)?	☐	☐

If yes, who? _____

9. Do you use drugs illegally?	☐	☐
10. Did you have a drink containing alcohol in the last year?	☐	☐

11. How many children do you have? _____

12. What is your occupation? _____

13. Do you have hazardous exposures in your occupation?	☐	☐
14. Are you exposed to agricultural chemicals?	☐	☐
15. Do you exercise regularly?	☐	☐
16. Do you consume caffeine on a daily basis?	☐	☐
17. Have you traveled outside the US within the last six months?	☐	☐
18. Are you sexually active?	☐	☐
19. Do you have an advanced directive or living will?	☐	☐
20. If no, would you like to learn about advanced directives or living wills?	☐	☐
21. Do you have problems with vision?	☐	☐
22. Do you have problems with hearing?	☐	☐
23. Do you have problems with reading?	☐	☐

MID-DELTA HEALTH SYSTEMS, INC.

Application for Reduced Fees

It is necessary for us to ask personal questions in order to give you a discount on your medical/dental expenses. This information will be kept on file in our clinic in strict confidence. You must verify your income at least once every year. Proof of Household Income may include:

- Your yearly income tax return and/or a copy of your W-2 form
- 1 current pay check stub
- A copy of your social security checks
- Checks or documents or Other income you may receive

Your annual household income will be used to calculate the level of your discount.

Responsible Party Name:_____Acct#_____
Address:_____City:_____State:____Zip_____
DOB:_____SSN#_____-_____-_____Telephone:_____
***TOTAL number living in your household, include yourself:_____**
Marital Status(Circle One): Single Married Separated Divorced Widow(er)
***Is anyone in your household employed? Yes or No**
List names of other members of household:

_____

_____

_____

I declare the above information is true and I have given MDHS permission to investigate any information given in this application. I understand that this information will be kept in strict confidence. I also understand that if my income should change that I am required to notify the receptionist on my next visit.

If you do NOT wish to apply for our Sliding Fee Scale:

Mid-Delta is a Federally Qualified Health Center. We are required to obtain household income information for reporting purposes. Please indicate your family's annual income. This helps us report income data even if you are not applying for the sliding fee scale.

How many people are in your household? _____

____ $0 - $10,000	____ $10,000 - $20,000	____ $20,000 - $30,000	____ $30,000 - $40,000
____ $40,000 - $50,000	____ $50,000 - $60,000	____ $60,000 - $70,000	____ $70,000 - $80,000
____ $80,000 - $90,000	____ $90,000 - $100,000	____$100,000 +	____ Wish not to disclose

□ **I refuse to provide my proof of income to apply for the reduced fees. In doing so, I agree that I will be responsible for the bill in full. (ONLY CHECK BOX IF YOU ARE NOT PROVIDING)**

_____ _____ _____

Responsible Party Signature Date Interviewer Signature

OFFICE USE ONLY

Weekly Gross Pay $_____x4.334=
Bi-Weekly Gross Pay $_____x2.167=
Twice Monthly Gross Pay $_____x2.00=
Monthly Gross Pay $_____x 12=
Totals x 12 Months
Total Annual Income: $_____
Expiration Date: _____(1 year from today)