BOSTON MOUNTAIN
Rural Health Center, Inc.
A Baptist Health Affiliate

CONSENT TO TREATMENT

Name of Patient: _____

I hereby voluntarily consent on behalf of (**CHECK ONE**) ☐ myself ☐ a minor for whom I am legally responsible (the "Patient") to outpatient care from Boston Mountain Rural Health Center, Inc. ("Boston Mountain"), including: examination, diagnosis, and medical treatment. I further consent to the performance of medically necessary diagnostic procedures, examinations, and medical treatment by Boston Mountain's medical personnel. I understand that this consent remains in effect so long as the Patient is a patient of Boston Mountain.

Authorization to Release Information
I hereby authorize Boston Mountain to release any necessary information acquired in the course of the Patient's examination or treatment to any authorized agent related to treatment, payment, or healthcare operations.

Acknowledgement
I acknowledge that I am responsible for the payment of the Patient's account balance.

Notification of Privacy
I have received a copy, read, and understand the Boston Mountain Notice of Privacy Practices.

Authorization to Access Medical Records
I hereby authorize Boston Mountain to access the Patient's medical records and protected health information.

☐ (**CHECK IF APPLICABLE**) I authorize the following individual(s) to consent to and authorize medical treatment for the Patient:_____

Full Name	Relationship to Patient	Telephone Number
Full Name	Relationship to Patient	Telephone Number

Authorization to Pay Benefits to Boston Mountain

(**CHECK ONE**)

☐ Private Insurance

I authorize Boston Mountain to file insurance and third party payor claims for services rendered to the Patient. I understand that insurance is filed as a courtesy and that I am responsible for payment of all services within ninety (90) days. I also authorize the release of all necessary medical information as needed for reimbursement from my insurers. I authorize payment of medical benefits by any insurance, whether to Boston Mountain or myself.

☐ Medicare Insurance

I authorize any holder of medical information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information related to services provided to the Patient and reimbursed by Medicare. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that it is mandatory to notify Boston Mountain of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 3801-3812 provides penalties for withholding information). Regulations pertaining to Medicare assignment of benefits may apply.

☐ Medi-Gap

I authorize any holder of medical or other information about me to release to Boston Mountain any information related to services provided to the Patient that is subject to "Medi-Gap" coverage. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts the assignment. I understand that Boston Mountain may not accept assignments on all Medi-Gap claims. I agree to be responsible all amounts not covered by Medi-Gap coverage.

I understand and agree to this form on behalf of the Patient.

_____	_____	_____	
Name	Relationship to Patient (if not you)	Signature	Date

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First Name: _____ MI: _____ Last Name: _____

Address: _____

City *State* *Zip Code*

Sex(Circle): **Male, Female, Transgender, Unknown**

Home Phone: _____ Date of Birth: _____

Cell Phone: _____ Social Security #: _____ Email: _____

Employer: _____ Work Phone: _____Cell Phone_____

Ethnicity(circle): **Hispanic or Latino, Not Hispanic, Refused to Report**

Race(circle): **Asian, American Indian/Alaska Native, Black/African American, Native Hawaiian, Pacific Islander, White, More Than One Race, Unreported/Refused to Report Race**

Primary Language(circle): **English, Indian, Spanish, Russian, Other**

Marital Status(circle): **Single, Married, Divorced, Widowed, Legally Separated, Partner, Unknown**

Veteran (circle): **Yes/No**

Agricultural Worker: Yes/No *(If "Yes," please specify: seasonal, migrant, employed farm worker, unemployed farm worker)*

Start Date: _____ Stop Date: _____

Public Housing: Yes/No Start Date: _____ Stop Date: _____

Homeless: Yes/No Start Date: _____ Stop Date: _____

(If "Yes," please specify: homeless shelter, street, transitional, doubling up, other)

Primary Insurance Information

Name: _____ DOB: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Relationship to Patient: _____

ID#: _____ GROUP#: _____

Secondary Insurance Information

Name: _____ DOB: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Relationship to Patient: _____

ID#: _____ GROUP#: _____

Minor Information (If Applicable)

Father's Name: _____DOB: _____ SS#: _____

Home Phone: _____Cell Phone: _____

Mother's Name: _____ DOB: _____ SS#: _____

Home Phone: _____Cell Phone: _____

Legal Guardian (If Applicable) _____ **VERIFICATION REQUIRED**

Pharmacy Name: _____ **Location**:_____

I hereby certify that the above information is correct.

_____ _____

Patient or Responsible Party Signature Date

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NEW PATIENT HISTORY FORM

To our new patients: To help us establish you with our practice, please provide us with your complete health history.

Personal History (Patient) **Date -**_____

Name: _____ Date of Birth____/____/_____(mm/dd/yyyy) Age_____

PERSONAL AND FAMILY HISTORY

Check those that apply:

	Yourself	Mother	Father	Grandparents	Sister/ Brother	Spouse	Children
AIDS							
Alcoholism							
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Breast Cancer							
Cancer							
Colon Cancer							
COPD							
Depression							
Diabetes							
Emphysema							
Epilepsy							
Glaucoma							
Heart Attack							
Heart Trouble							
High Blood Pressure							
IBS							
Kidney Disease							
Liver Disease							
Mental Illness							
Migraine Headaches							
Pneumonia							
Prostate Cancer							
Sickle Cell Anemia							
Stroke							
Suicide							
Tuberculosis							
Ulcers							
Other							

ALLERGIES: Like – Food, Pollens, Odors, Medicines, Pets etc…

_____

_____

Current Medications	Dose	Times / Day

Current Herbs / Vitamins/ Homeopathy/ Supplements	Dose	Times / Day

PAST MEDICAL, SURGICAL & TRAUMA HISTORY **Patient Name:**

List prior illness, injury, hospitalization, surgery, and/or trauma:

Reason: **Date/Month and Year**

_____

_____

_____

_____

_____

This history record has been designed to facilitate our patients to assess their health issues in detail.

_____

Date Patient/ Guardian signature that filled out the history

Implemented 8/3/15

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Notice of Privacy Practices/HIPAA Privacy Services

Boston Mountain Rural Health Center is committed to providing security for patient privacy and confidentiality. This organization collects, uses, and discloses personal health information only in conformance with state and federal laws and your personal authorization. Please understand that this may include the collection of other sources of information available, such as medication and prescription history and verification of insurance eligibility.

[ ] I have received a copy of the Boston Mountain Rural Health Center Notice of Privacy Practices

BMRHC participates in the State Health Alliance for Records Exchange (SHARE). SHARE is a way of sharing your health information statewide among your doctors, hospitals, labs, radiology centers, and other health care providers through secure, electronic means. With access to your up-to-date health information, your doctor can provide safer, more effective health care that is tailored to your personal medical needs. If you wish to opt-out, you must ask your health care provider for and complete an Opt-Out Form. You can also opt-out for your minor child (under the age of 18) using the same process.

In an effort to serve you more efficiently, BMRHC uses an automated system to remind you of appointments, lab notices by portal, health maintenance reminders, prescription confirmation and general notifications. You will be contacted using the latest contact information on file. Please understand that it is your responsibility to inform BMRHC when there are updates to your personal information.

[ ] I **DO** want to participate in the automated telephone services. (By checking this, I understand that anyone answering the telephone will receive this information and/or messages will be left on my answering machine.

[ ] I **DO** want to participate in text message services.

[ ] I **DO** want to participate in the web enabling information system/patient portal. (Exclude age 11-17yrs. of age.)

Email address: _____

[ ] I **DO NOT** wish to participate in the automated telephone or web enabling information system.

Boston Mountain Rural Health Center also realizes you may have family members or significant people whom you may wish your provider speak with regarding your healthcare information. Without your written consent, we cannot release any information to anyone except for purposes outlined in the HIPAA privacy act.

Please specify the individual(s) and their relationship to you that your provider has permission to discuss your healthcare information.

Individual's Name	**Phone Number**	**Relationship to You**
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____
Patient's Signature Date

_____ _____ _____
Signature of Patient's Representative Relationship to Patient Date

SHARE
Version Number: 1.0

Health Information Exchange Patient Opt-Out Form

This form is for patients who DO NOT wish to participate in the Arkansas State Health Alliance for Records Exchange (SHARE) or who wish to revoke an earlier decision.

This form allows you to limit electronic access of your health information. The Arkansas State Health Alliance for Records Exchange (SHARE) is an electronic health information exchange that your treating providers use to share health care information about you in order to provide higher quality and better coordinated care. Your health information will be available electronically to your treating providers unless you decide to opt-out and not have your information shared electronically.

If you opt-out, your treating providers will not be able to access your health information by making an electronic inquiry through SHARE except in the case of a medical emergency. You have the option to change your mind and terminate your opt out decision. You may request a copy of this form. If you sign as a legal representative, all references in this form refer to the patient.

INSTRUCTIONS: If you do not wish to make your health information available through SHARE, check only one box and provide all requested information below. Please print, sign and date the form.

☐	**Request to Opt-Out.** I choose to opt-out. I do not want my authorized health care providers to access my health information by making an electronic inquiry through SHARE.

OR

☐	**Request to terminate my previous decision to Opt-Out.** I want to reverse my previous decision to opt-out. By completing and signing this form, I am allowing my health information to be accessible to my authorized health care providers through SHARE, unless restricted by applicable law.

Patient Name: _____ **Gender**: Male / Female
Last, First, Middle Initial (Circle One)

Date of Birth: ____/_____/_____ **Previous or Other Last Name**: _____

Street Address: _____ **Apt. #**: _____

City: _____ **State**: _____ **ZIP**: _____

Legal Representative: _____
(If Applicable)

Relationship to Patient: _____

Signature: _____ **Date**: ___/____/____

The portion below must be completed by Health Care Provider. *Please ensure your patient has completed all information above.*

Name of Health Care Provider: _____

Phone: _____ **Fax:** _____

Address: _____

Date form entered into electronic system by SHARE: _____/_____/_____

Arkansas Office of Health Information Technology

BOSTON MOUNTAIN
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Consent to Videoconference

Patient Name:_____ Date of Birth:_____

I have read and understand this telemedicine information sheet and agree to participate in the telemedicine consult in which my image and my protected health information will be transmitted electronically through the videoconference(s) to physicians, and health care professionals that are authorized to receive such information for the purpose of providing medical diagnostic assessment and treatment services to me.

I understand that network and software security protocols are in place to protect the confidentiality of my personal health information, and that these protocols include measures to safeguard and ensure the integrity of this information against intentional or unintentional interception. In very rare instances, security protocols could fail, causing a breach of privacy of personal health information. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that BMRHC privacy policies apply to these services.

I understand that I can withdraw my permission at any time prior to the videoconference and/or my interrupt the videoconference at any time. In either case, I understand that no action will be taken against me, and I may still pursue a consultation in person with a physician or other health care professional. I also understand that if I interrupt the videoconference, the consultation will be incomplete. Therefore, I understand that health care professionals involved in the videoconference will be unable to provider treatment or services to me at that time.

I have read this document in its entirety, and any questions I have asked about this consent have been answered to my satisfaction. I fully understand the terms of my consent to release of protected health information to participants in telemedicine videoconferences.

I understand that there are limits to telemedicine technology. Therefore, there is no guarantee that this telemedicine session will eliminate the need for me to see a specialist in person in order to receive appropriate or additional treatment for my current condition.

_____ _____

Signature of Patient or Legal Representative of Patient Date

IF LEGAL REPRESENTATIVE OF PATIENT PRINT NAME:_____

Authority of Legal Representation: _____

(Parent, Guardian, Power of Attorney, or Other Appropriate Description)

Witness: _____

7/19/2013 RR
Revised 07/31/2015