Patient Information/Registration – SAMA HealthCare Services

To properly identify and provide you with the best medical services, please complete and sign the following

CONSENT FOR TREATMENT: I consent to necessary medical treatment and services which may include injection or ingestion of drugs or medications, the performance of certain tests, procedures, surgeries, and/or other studies which may be used by the treating physician or clinical staff.

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize SAMA HealthCare Services (SAMA) to furnish any medical information properly requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on-the-job or work related injury. I also authorize SAMA to obtain medical history and information from outside sources to include electronic media.

NOTICE OF PRIVACY PRACTICES RECEIPT: I acknowledge the offer and/or receipt of SAMA's *Notice of Privacy Practices*. I authorize SAMA to release my medical information to those individuals whom, in SAMA's professional judgment, are involved in my medical care unless specified on the *Form to Request Restrictions on Use and Disclosure of PHI*.

ASSIGNMENT OF BENEFITS: I authorize payments for services be made directly to SAMA which may otherwise be payable to me from all sources including, but not limited to, my medical insurance company, my employer's workman compensation carrier, or other parties for surgical or medical benefits with whom I have contracted. Such benefits shall not exceed SAMA's billed charges for these services. I understand that I am financially responsible to SAMA for charges not covered by this assignment and will adhere to the financial policies of SAMA in the collection of these charges. I accept full responsibility for providing SAMA accurate and complete information needed for their assisting me in processing my claims for reimbursement of medical services. I authorize the refund of overpaid insurance benefits where my coverage is subject to coordination of benefits.

SAMA Healthcare Services PA complies with applicable Federal civil rights law and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

GUARANTEE OF ACCOUNT: For services furnished by and through SAMA, I personally guarantee payment of all my accounts for services rendered to me, to my dependents, and/or on my account. For payment of said accounts for services, I waive all claims of exemption under the state of Arkansas and agree to pay all costs of collection, including attorney and court fees. ***I have read and agree to SAMA's Financial Policy.***

New patients, patients not seen at SAMA during the past three years, and patients that have had a change in billing, employment, or contact information are required to complete the following.

Patient Last Name	Patient First Name	Middle Name	Birth Date

Patient Mailing Address	Employer Company Name (If unemployed, enter "Unemployed)

Patient City	State	Zip	Employer Address

Home Phone	Cell Phone	Employer City	State	Zip

Patient Social Security Number	Employer Phone	Employer contact person

***E-mail:** Gender: [ ] Male [ ] Female Marital status: [ ] Single [ ] Married [ ] Divorced [ ] Widow(er)

Emergency contact name not living with you	Relationship	Emergency Contact Phone

Insurance Information:

Insurance Company Name	Policy ID #	Group #	Insurance Company Name (Secondary)	Policy ID #

Insurance Subscriber Information: If someone other than you is the Insurance Subscriber, please complete the following.

Subscriber Name (Policy Holder)	Subscriber Birth Date	SS #	Insurance Name	Policy ID #

Guarantor of account: A copy and/or evidence of insurance coverage, payment of past due balances, the insured's estimated portion of the charges, the required co-payment, and/or the estimated payment in full will be required each visit before services are provided.
If the Guarantor is NOT the patient listed above, the relationship to the patient is [ ] Spouse [ ] Parent/Guardian [ ] Child [ ] Other _____. Please complete the following.

Guarantor last name	Guarantor first name	Middle name	Birth date

Guarantor mailing address	Guarantor Social Security Number

Guarantor City	State	Zip	Employer Company Name (If unemployed, enter "Unemployed"

Guarantor Home Phone	Cell Phone	Employer City	State	Zip

To the best of my knowledge and ability, the information provided herein is accurate and complete. By my signature here, I confirm I have read and agree to the conditions and my responsibilities as outlined above.

Signed Date

Financial Policy
SAMA HealthCare Services

For all medical services provided in this office, inclusive of diagnostic laboratory testing and/or radiology studies, ***payment is due at time of services***. Unless other arrangements have been made in advance with our Business Office, payment is expected upon checkout in cash or, with proper identification, by personal check, VISA, MasterCard, Discover, or American Express.

For our **patients with medical insurance** coverage, the appropriate co-payment is due at registration and the known deductible, or non-covered billable portion of the charges are due and payable at the time of service.

For **self-insured patients**, For services exceeding $50 on the same day, a 20% cash discount will be given for payment in full.

In a divorce or separation case where a child is being treated, **regardless of who has been awarded custody or financial responsibility** for the child, the person bringing the child for treatment is responsible for the payment of services rendered at the time of service.

When patient insurance coverage is confirmed, **SAMA will file** the remaining claim amount with the **patient's primary insurance. The patient is responsible for filing claims to their secondary insurance carrier.**

After your insurance processes a claim, all remaining amounts after contractual adjustments shall be **patient responsibility** and due in full. When patient insurance fails to respond to a properly filed claim 30 days after our submittal, any remaining amounts shall be **patient responsibility** and due in full.

Miscellaneous Fees may be added to your account as follows:

- $20 – Missed "confirmed" appointment without at least 2 hour notice before scheduled start
- $20 – After-hours call to our on-call Physician
- $10 – Prescription requests received and filled without an office visit
- $10 – Medical advice/care given by phone – after first 10 minutes
- $20 – Special *patient requested* forms requiring direct supervision of a Physician

Payment arrangements: SAMA Healthcare Services is not, and has no desire to be, a financial institution which extends "credit" to its patients. We work with our patients on a case by case basis in which account balances must be paid off within 6 months from date of service. Please contact our business department with your specific request.

Patients with account balances will receive a **monthly statement of activity**. Payment in full is due upon receipt of statement unless specific payment arrangements have been made with our Business Office. **Accounts that are not paid in full will be charged a $5 monthly fee until the account is paid in full.**

We will make every effort to work with you and your insurance carrier, if applicable, to keep your account current. If circumstances of non-compliance and/or non-cooperation persist, we reserve the right to take whatever legal or other action is necessary to bring your account current, including, but not limited to, outside collection proceedings and/or termination from the practice. **An additional fee equaling 40% of your unpaid balance will be added to your account if outside collection proceedings become necessary. All accounts over 90 days will go to collections.**

I have read, understand, and agree to this Financial Policy.

Patient Name	Date of Birth	Signature
	___/___/___	

Address _____

City	State	Zip

Authorization for Release of Information-From/ To SAMA

By my signature below, I hereby authorize my medical/health records or information as stated below to be released to/ by SAMA HealthCare Services to/from the Persons/Physicians designated. (Please complete all sections)

Last Name First Name Middle Initial Maiden or a.k.a Name

Birth Date Social Security Number

Home Address City State Zip Code

Release records/Information TO/ FROM:

Provider/Physicians/Facility Name

Address

City State Zip Code

Telephone # Fax #

Release records/Information TO/FROM:

Provider/Physicians/Facility Name

Address

City State Zip Code

Telephone# Fax #

The information I authorize for release includes only the items marked as follows:

	SEND ITEM(S)	DATES FROM/TO			PURPOSE OF RECORDS RELEASE
	All records and notes				**Changing Physicians**
	History & Physical exams				**Consultation**
	Progress Notes				**Continuing Care**
	Laboratory Reports				**Employer Work Comp**
	Radiology Reports				**Insurance Purposes**
	Substance Abuse notes (alcohol/drugs)				**Legal Purposes**
	Mental Health notes including psychotherapy				**School Records**
	HIV/AIDS related notes and test results				**Other**
	Other (specify)				

1. I understand that I may revoke this authorization at any time by notifying the releasing Provider/Physician Facility in writing and the revocation will be effective on the date notification is received except to the extent action has already been taken in reliance upon my prior authorization.
2. I understand further medical care may be denied by the releasing Provider/Physicians/Facility following this release.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.
4. I understand that this authorization will expire exactly 6 months after I have signed this form.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT MEDICAL RECORDS AT 862-2400

My signature or that of my parent, legal guardian, or other authorized person Today's Date

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SAMA HealthCare Services

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Please keep this copy for your records

HIPAA Notice of Privacy Practices

SAMA HealthCare Services
600 South Timberlane
El Dorado, AR 71730
870-862-2400

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.
Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure the physician has the necessary information to diagnose or treat you.
Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donations, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply)- Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information- This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications- You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information- If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures- You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14,2003, or six years prior to the date of the request.

You have the right to receive notice of a branch- We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Terri Townley, HIPAA COMPLIANCE OFFICER 870-862-2400 ttownley@samahealthcare.com

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form.
Please not that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

SAMA
HEALTHCARE

SAMA Healthcare Participates in Comprehensive Primary Care Plus (CPC+)

Our practice is participating in CPC+, the nation's largest-ever program to improve primary care.

Giving doctors extra support to help you get better care

Through CPC+, our insurers will give our practice additional resources to help us better manage your care. We hope to provide you the highest quality patient-centered care.

More information for traditional Medicare (Part A and Part B) beneficiaries

To help us take better care of you, Medicare will start sharing some of your personal health information with us. This will help provide us with a more complete picture of your health and be better able to coordinate your care.

If you want to stop Medicare from sharing this information, you should call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Your Medicare benefits aren't changing. You still have the right to use or visit any doctor or hospital that accepts Medicare, at any time. Your doctor may continue to recommend that you see particular doctors for your specific health needs, but it's always your choice which doctors you use or hospital you visit.

Questions?

If you have questions or concerns, you can call SAMA at 870-862-2400, or bring it up next time you're in the office for an appointment. You can also visit https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus, contact CPC+ Support at CPCPlus@Telligen.com or 1-888-372-3280, or call 1-800-MEDICARE with questions.