



Fax Cover Sheet

To:	ACH Telephone /On-line E&M service Registration	From:	
Fax No.:	501-978-6483	Fax No.:	
Phone No.:	501-364-5465	Phone No.:	
Re:		Date:	
Total Pages Including Cover Sheet:		Time:	

Consultation date (if known): _____

Requesting Provider: _____

Provider to be consulted: _____

Reason for consult: _____

Forms to be attached:

- Telephone/On-line E&M services consent & payment policy signed
- Notice of Privacy Practices acknowledgement form signed
- Patient Information form completed
- Copy of insurance and/or Medicaid card(s)
- Insurance and/or Medicaid referrals as required

If you do not receive all pages, please contact us immediately at the telephone number listed above.

UAMS CONFIDENTIALITY NOTICE

The information contained in this facsimile document may be privileged, confidential, and protected under applicable law and is intended solely for the use of the individual or entity to whom it is addressed. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy the document.

TELEPHONE/ON-LINE E&M PATIENT INFORMATION FORM

PATIENT INFORMATION:

Date of Birth: _____ Race: _____ SS# _____

Sex: _____ Marital Status: _____

Patient Name: _____
(last) (first) (middle)

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: _____ Work Phone: _____

Mother's Name: _____ Mother's DOB: _____

GUARANTOR INFORMATION (if applicable):

Name: _____ DOB: _____

Employer: _____ SS# _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: _____ Work Phone: _____

Guarantor Employer: _____ Employer Phone #: _____

Employer Address: _____

PRIMARY INSURANCE INFORMATION:

Name of Insurance: _____ Customer Service Phone: _____

Policy #: _____ Group Name and/or Number: _____

Policy Holder: _____ Relationship to Patient: _____

Policy Holder DOB: _____ Employer Name and Location: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

MEDICAID/ARKIDS INFORMATION:

Policy Number: _____

PCP Name: _____ City: _____ State: _____

TELEPHONE/ON-LINE E&M SERVICES CONSENT & PAYMENT POLICY

PATIENT'S NAME: _____ DOB: _____

DATE OF SERVICE: _____

CONSENT TO TREAT: I hereby authorize examination and treatment by members of the Medical Staff of the Arkansas Children's Hospital, residents and interns, and any assistants or designees deemed necessary in their judgment. I understand that the examination may include the use of X-rays, laboratory test and other routine diagnostic procedures deemed necessary by the physicians. I realize that among those who attend patients are medical, nursing, and other health care personnel in training who may be present during patient care as part of their education. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatment or examinations.

RELEASE OF INFORMATION: I authorize the release of information concerning this visit as may be required for processing reimbursement claims, for audits to verify such claims, and to the referring agency, referring physician, and/or family physician.

ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT: I hereby authorize payment directly to the provider of third-party benefits otherwise payable to me, not to exceed the provider's regular charges. I understand that I am financially responsible to the provider and I agree to pay the provider all amounts incurred by the above named patient not covered by third-party payor. I hereby authorize the provider to take any and all necessary action to collect, in their own names, said benefits directly from the third-party payor. I consent that any legal action to collect payment for services rendered may be brought in Pulaski County, Arkansas, and venue laws are expressly waived.

Patient/Legal Representative's Signature Relationship to patient Date Time

Printed Name of Patient/Legal Representative Witness' Signature

PAYMENT POLICY

Most insurance companies, including Arkansas Medicaid, totally exclude telephone and online encounters as a covered benefit. The purpose of this notice is to help you make an informed choice about whether or not you want to receive these services, knowing you may have to pay for them yourself. Please contact your carrier for coverage guidelines related to your specific policy. The billing agency is Children's University Medical Group.

An estimate of charges by visit type is included for your reference. By signing this notice below, you acknowledge understanding that you may be personally responsible for payment of telephone/online services.

Telephone evaluation & management services \$26 - \$73
On line evaluation & management service \$35

Patient/Legal Representative's Signature Relationship to patient Date Time

Printed Name of Patient/Legal Representative Witness' Signature



UNIVERSITY OF ARKANSAS
FOR MEDICAL SCIENCES

NOTICE OF PRIVACY PRACTICES

Effective Date: May 1, 2009

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 is provided on behalf of the University of Arkansas for Medical Sciences including its Medical Center and clinics, Psychiatric Research Institute, Area Health Education Centers, and other facilities ("UAMS"). UAMS provides patient care through a healthcare system committed to education and research.

PURPOSE: This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out treatment, payment or healthcare operations and for other purposes permitted or required by law. "Protected Health Information" is information that may identify the patient and that relates to the patient's past, present or future physical or mental health, and may include name, address, phone numbers and other identifying information.

We are required to give you this Notice and to maintain the privacy of your Protected Health Information. We must abide by this Notice, but we reserve the right to change the privacy practices described in it. A current version of this Notice, with required revisions, if any, may be obtained from the UAMS web site, www.uams.edu and will be posted in prominent areas of our facilities. You may also receive a current copy by sending a written request to the UAMS HIPAA Office, 4301 W. Markham #829, Little Rock, AR 72205.

We understand that medical information about you and your health is personal and confidential, and we are committed to protecting the confidentiality of your medical information. We create a record of the care and services you receive at UAMS Medical Center and its clinics, Area Health Education Centers and other UAMS facilities. We need this record to provide services to you and to comply with certain legal requirements. This Notice will tell you about the ways we may use and disclose your information. We also describe your rights and certain obligations we have to use and disclose your health information.

If you believe your Privacy Rights have been violated, you may complain to us or to the U.S. Secretary of Health and Human Services. To file a complaint with us, you may send a letter describing the violation to the UAMS HIPAA Officer, 4301 W. Markham #829, Little Rock, AR 72205. There will be no retaliation for filing a complaint.

If you have questions or need more information, contact the UAMS HIPAA Officer at 501-614-2187.

WHO WILL FOLLOW THIS NOTICE: This Notice describes the practices of UAMS healthcare professionals, employees, volunteers and others who work or provide healthcare services at any UAMS facility, including students-in-training.

ACKNOWLEDGMENT: You will be asked to sign an Acknowledgment of receipt of this Notice. The delivery of your healthcare services will in no way be conditioned upon the signing of this Acknowledgment.

Your Privacy Rights. You have the following rights relating to your Protected Health Information and may:

- Obtain a current paper copy of this Notice.
- Inspect or obtain a copy of your records. Your request to obtain a copy of your medical records must be in writing. You may be charged a fee for the cost of copying, mailing or other supplies. We are allowed to deny this request under certain circumstances. In some situations, you have the right to have the denial of your request reviewed by a licensed healthcare professional identified by UAMS who was not involved in the original denial decision. We will comply with the outcome of this review.
- Request that we amend your record, if you feel the information is incomplete or incorrect. We are allowed to deny this request in certain circumstances and may ask you to put these requests in writing and provide a reason that supports your request.
- Request in writing a restriction on certain uses and disclosures of your information. We are not required to agree to the requested restrictions in all circumstances.
- Obtain a record of certain disclosures of your Protected Health Information.
- Make a reasonable request to have confidential communications of your Protected Health Information sent to you by alternative means or at alternative locations.
- We will obtain your written permission for uses and disclosures of your Protected Health Information that are not covered by the Notice or permitted by law. Except to the extent that the use or disclosure has already occurred, you may cancel this permission. This request to cancel must be put in writing.
- Submit any written requests to inspect, copy or amend your records to the Medical Records Department.

Our Responsibilities. We are required to protect the privacy of your Protected Health Information, abide by the terms of the Notice, and make the Notice available to you.

Examples of Uses & Disclosures

We will use your Protected Health Information for treatment. Certain information obtained by a nurse, doctor, therapist, or other healthcare worker will be put into your record and used to plan and manage your treatment. We may provide reports or other information to your doctor or other authorized persons who are involved in your care.

We will use your Protected Health Information for payment. A bill will be sent to you and/or your insurance company with information about your diagnosis, procedures and supplies used.

We will use your Protected Health Information for regular healthcare operations. The Medical Staff and other healthcare workers may use your Protected Health Information to check on the care you received, how you responded to it, and for other business purposes related to operating the hospital or clinics.

Business Associates: We may share some of your Protected Health Information with outside people or companies who provide services for us, such as typing physician reports.

Patient Directory: Unless you tell us not to, we may use and disclose your name, location in the facility, and general condition to people who ask for you by name. If provided by you, your religious affiliation will only be given to members of the clergy. If you are a patient at the Psychiatric Research Institute (PRI), you will not be part of the Patient Directory while you are at the PRI, and we will not provide directory information to people who ask for you by name, unless you specifically tell us to.

Notification: We may use or disclose your Protected Health Information to notify a family member or other person involved in your care, your location and general condition unless you tell us not to do so.

Communication with family: We may share your Protected Health Information with a family member, a close personal friend, or a person that you identify, if we determine they are involved in your care or in payment for your care, unless you tell us not to do so.

Research: Your Protected Health Information may be used for research purposes in certain circumstances with your permission, or after we receive approval from a special review board whose members review and approve the research project.

Coroners, Medical Examiners, Funeral Directors: We may disclose your Protected Health Information to these people, to the extent allowed by law, so that they may carry out their duties.

Organ Donor Organizations: We may share your Protected Health Information with the organ donation agency for the purpose of tissue or organ donation in certain circumstances and as required by law.

Contacts: We may contact you to provide appointment reminders or to tell you about new treatments or services.

Fundraising and Marketing: We may contact you as part of any fundraising or marketing efforts.

Food and Drug Administration (FDA): We may share your Protected Health Information with certain government agencies like the FDA so they can recall drugs or equipment.

Workers Compensation: We may disclose your Protected Health Information for workers' compensation claims.

Public Health: We may give your Protected Health Information to public health agencies who are charged with preventing or controlling disease, injury or disability and as required by law.

Communicable Disease: We may disclose your Protected Health Information to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition, if authorized by law to do so, such as a disease requiring isolation.

Correctional Institution: If you are an inmate of a correctional institution, we may disclose your Protected Health Information needed for your health or the health and safety of others.

Law Enforcement: We must disclose your Protected Health Information for law enforcement purposes as required by law.

As Required by Law: We must disclose your Protected Health Information when required by federal, state or local law.

Health Oversight: We must disclose your Protected Health Information to a health oversight agency for activities authorized by law, such as investigations and inspections. Oversight agencies are those that oversee the healthcare system, government benefit programs, such as Medicaid, and other government regulatory programs.

Abuse or Neglect: We must disclose your Protected Health Information to government authorities that are authorized by law to receive reports of suspected abuse or neglect.

Legal Proceedings: We may disclose your Protected Health Information in the course of any judicial or administrative proceeding or in response to a court order, subpoena, discovery request or other lawful process.

Required Uses and Disclosures: We must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the HIPAA Privacy Regulations.

To Avoid Harm: We may use and disclose information about you when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person.

For Specific Government Functions: In certain situations, we may disclose Protected Health Information of military personnel and veterans. We may disclose your Protected Health Information for national security activities required by law.

UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

JOINT NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Joint Notice of Privacy Practices for the University of Arkansas for Medical Sciences.

Print Name:

Signature:

Relationship to Patient

Date:
