MACHEN FAMILY MEDICAL

Caring for you and your family

Thank you for choosing Machen Family Medical as your medical home. Heidi Machen is a board certified Advanced Nurse Practitioner. Heidi is licensed to diagnose and treat acute and chronic illnesses independently. The Machen Family Medical team is committed to fostering open trusting relationships with our patients and their families while providing quality health care using the most current evidence based medicine guidelines. In addition to diagnosing and treating acute and chronic illnesses, we provide routine health screenings and counseling on lifestyle changes in an effort to prevent illnesses before they develop. If a health condition arises that requires care from another specialist, Machen Family Medical will be there to guide you and assist in coordinating your care. We will work with you to achieve the best possible outcome in the most effective manner.

Please complete and return the attached new patient forms to Machen Family Medical. In order to establish care and schedule your initial visit in our clinic we also require a copy of your driver's license (or other photo identification) and any insurance cards we will need to file on your behalf. Machen Family Medical is a participating provider for most major insurance carriers but we do not accept or file for Champus, Humana, or Medicaid as a primary insurance. It is the responsibility of the patient to confirm with their insurance carrier that Heidi are in-network with their particular plan. It is essential that we have a copy of the insurance card to ensure we have accurate contact information for prior authorizations on testing. Machen Family Medical staff will not schedule an initial visit without the above information on file.

Check-in on the day of your appointments with Machen Family Medical will include confirmation of your contact information, insurance coverage and acceptance of payment. All co-pays, co-insurance or deductibles are due at check-in on the day of service. Machen Family Medical does not carry a balance or charge on patients' accounts.

Your initial visit with Machen Family Medical will include a physical exam and in-depth history to expound on the Initial Medical History Form that you have completed in this packet. We request that you also bring any and all medications (both prescription and over the counter) that you are currently taking.

It is our office policy that no controlled medications are prescribed at an initial visit. If a narcotic or other controlled substance is requested, you will be given information about our Opioid Treatment Program. Participation in this program includes a signed Opioid Treatment Agreement, initial and periodic urine/oral drug, and periodic pill counts. Acceptance into this program is at the discretion of Heidi and following review of past medical records and initial drug screening results. Patients will be contacted if they meet the treatment guidelines and will be required to attend routing office visits to participant in their treatment plan to remain eligible for prescription obtainment.

Though we do our very best to run on time during clinic, we acknowledge that some situations are more complicated and may require more time in an exam room. We hope you understand that when Heidi are in your exam room, you will be the central focus of their attention.

1995 HARRISON STREET, BATESVILLE, ARKANSAS 72501

(870) 262 - 8024

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Machen Family Medical Hours of Operation:

Monday:	8:00 am – 12:00 pm	1:00 pm – 6:00 pm
Tuesday:	8:00 am – 12:00 pm	1:00 pm – 6:00 pm
Wednesday:	8:00 am – 12:00 pm	1:00 pm – 6:00 pm
Thursday:	8:00 am – 12:00 pm	1:00 pm – 6:00 pm
Friday:	Closed	

Though Machen Family Medical does not currently have an after-hours call coverage, we make a point to schedule same day appointments for all sick visits. We encourage our patients that require emergency treatment after hours to proceed to Sherwood Urgent Care or White River Medical Center Emergency Room. If your needs are urgent but do not require immediate after-hours treatment, we will be happy to work you in during the next clinic day. In addition, we are in the process of extending our hours of operations and call coverage and will update patients as these services become available.

At Machen Family Medical we stress the importance of preventative care and engaging our patients in participating in their treatment plan. Should your treatment require hospitalization you will be directed to White River Medical Center or another hospital facility for admittance by a hospitalist. A hospitalist will cover your care during the time you are inpatient as Heidi does not perform rounds. Upon discharge, your follow up appointment will be scheduled with Machen Family Medical. Our office will request records detailing your hospitalization and Heidi will review any changes necessary in your treatment plan during your follow up appointment.

Prescription refill requests should be directed through your pharmacy and allowed 24 hours for processing. The pharmacy will electronically request a refill. This request will be reviewed by the nursing staff and addressed by Heidi as the clinic schedule allows. You will be alerted if your request requires an appointment. Prescriptions for new medications, medications previously filled by another doctor, controlled medications, or antibiotics will only be addressed in a scheduled appointment.

If you have any questions, feel free to contact our office at (870) 262-8024. We look forward to serving your healthcare needs.

Sincerely,

Machen Family Medical

To schedule your initial visit please complete, sign and return/provide the following:

_____ Financial Policy
_____ Personal Representative Designation
_____ Medical Records Release
_____ Driver's License (or other photo identification)
_____ Insurance card(s)
_____ Initial Medical History

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FINANCIAL POLICY

Heidi Machen, APRN

Thank you for choosing Machen Family Medical as your healthcare provider. We are committed to quality patient care at a reasonable cost. The following statement of our financial policy that we require be read and signed prior to any services being rendered. Minors must be accompanied by a responsible party (guarantor) for his/her account.

Patient Information

Name: (Mr./Mrs./Miss/Dr.) _____

Preferred Name: _____

Social Security Number: _____ Date of Birth: _____

Home address: _____

Home / Cell Phone: _____ Work / Alternate Phone: _____

Email Address: _____ Preferred Contact: _____

Responsible Party Information

Name: (Mr./Mrs./Miss/Dr.) _____

Preferred Name: _____

Social Security Number: _____ Date of Birth: _____

Home address: _____

Home / Cell Phone: _____ Work / Alternate Phone: _____

Email Address: _____ Preferred Contact: _____

Unaccompanied minors will be denied non-emergent treatment unless payment is authorized by the responsible party.

Insurance Filing Information

- Please be aware that some of the services provided may non-covered services that are not considered reasonable and necessary by your insurance carrier (i.e. B12, laboratory work on day of an office visit, etc.)
- For those plans with which Machen Family Medical IS a participating provided:
    - ALL co-pays, co-insurance and deductibles are due at check-in on date of service.
    - To properly bill/contact your insurance company and avoid untimely delays due to inaccuracy, Machen Family Medical requires a copy of your insurance card for our records.
- For those plans with which Machen Family Medical IS NOT a participating provider:
    - Machen Family Medical does not accept assignment of insurance benefits or bill the insurance company. Your policy is a contract between yourself and your insurance company.
    - Payment by cash, check, or credit card is due at check-in on date of service.

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FINANCIAL POLICY

Heidi Machen, APRN

Insurance Plan Information

Primary Insurance Company: _____

Name of Policy Holder: _____

Date of Birth of Policy Holder: _____

Policy Number: _____

Group Number: _____

Secondary Insurance Company: _____

Name of Policy Holder: _____

Date of Birth of Policy Holder: _____

Policy Number: _____

Group Number: _____

Tertiary Insurance Company: _____

Name of Policy Holder: _____

Date of Birth of Policy Holder: _____

Policy Number: _____

Group Number: _____

Billing Authorization

- I hereby authorize Machen Family Medical to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare or commercial insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either r to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.
- I hereby assign payment directly to Machen Family Medical for medical and/or surgical benefits, if any, otherwise payable to me for services provided at the clinic (not to exceed my indebtedness to the clinic for those services.) I understand that I am financially responsible for charges not covered by my insurance.

I have read and understand the above Financial Policy and Benefits Authorization and agree to all provision outlined herein. I understand and agree that I will be responsible for payment of all fees related to collection of my account including attorney fees, collection fees, and court costs should this account become delinquent.

_____

Signature of Patient or Responsible Party Date

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MACHEN FAMILY MEDICAL
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Personal Representaive Designation

Heidi Machen, APRN

Patient's Name: _____

Date of Birth: _____

I authorize Machen Family Medical to release Personal Health Information to the person(s) named as my Personal Representative for the purpose of assisting with, or facilitating the coordination of payment of my health plan benefits and medical care. I also understand that if my Personal Representative is not a health care provider or other personal subject to federal privacy laws, my Personal Health Information may no longer be protected by those privacy laws and may be subject to redisclosure by my Personal Representative. Machen Family Medical is not responsibly should my Personal Representative further disclose my protected Personal Health Information. I further understand that I have the right to limit the information that is released under this authorization. Limitation for disclosure are identified below. By leaving this section blank, I am creating a "no limitation" on disclosure of Personal Health Information. I understand that changes to my list of Personal Representatives must be done in writing in coordination with a Machen Family Medical front office staff member.

Disclosure information: _____

_____

_____

Name: _____

Relationship to Patient: _____

Contact Number: _____

Name: _____

Relationship to Patient: _____

Contact Number: _____

Name: _____

Relationship to Patient: _____

Contact Number: _____

I, the undersigned, do hereby swear that I am the above-mentioned patient or an authorized legal representative of the above-mentioned patient. I have read and understand the content of this Personal Representative Form. My signed authorization is voluntary and I acknowledge that the information released may include protected and individually identifiable information about me.

_____

Signature of Patient or Responsible Party Date

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MACHEN FAMILY MEDICAL
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Initial Medical History

Heidi Machen, APRN

Demographic Information

Name: (Mr./Mrs./Miss/Dr.) _____

Preferred Name: _____

Social Security Number: _____ Date of Birth: _____

How did you hear about Machen Family Medical? _____

Previous physician: _____ **Date last seen:** _____

Reason for change: _____

Preferred pharmacy: _____

Allergies

☑ No Known Drug Allergies

☐ Medication: _____ Reaction: _____

☐ Medication: _____ Reaction: _____

Social History

Tobacco Use	Alcohol Use	Drug Use	Exercise	Caffeine Intake
☐ Never	☐ None	☐ None	☐ None	☐ None
☐ Cigar smoker	☐ Socially	☐ Marijuana	☐ 1-2 times per week	☐ Occasional
☐ Pipe smoker	☐ Daily	☐ Amphetamines	☐ 3-4 times per week	☐ Daily
☐ Chewing tobacco	☐ Heavy	☐ Other	☐ 5-7 times per week	
☐ Cigarette smoker __ packs per day for __ years	☐ Received treatment for abuse	☐ Received treatment for abuse		
☐ Former smoker quit year ____				

Are there any religious beliefs that would affect your medical care? (i.e. blood transfusion refusal, etc.)

☑ No ☐ Yes. Explain: _____

Are you currently employed?

☑ No ☐ Yes. Occupation/Employer: _____

If disabled/retired/unemployed, what was your primary occupation/type of work?

_____

What is your highest level of education completed?

☐ No schooling completed ☐ Some high school ☐ High School
☐ Some college ☐ Vocational ☐ University

What is your current marital status?

☐ Single/never married ☐ Married. Spouse's name: _____ ☐ Widowed ☐ Divorced

Do you have any children?

☐ No ☐ Yes. Number: _____

Personal Past Medical History

☐ Diabetes ☐ Heart Disease ☐ Seizures
☐ Hypertension / High Blood Pressure ☐ CVA / Stroke ☐ Neuropathy
☐ Hyperlipidemia / High Cholesterol ☐ Chronic Kidney Disease ☐ Sleep Apnea
☐ CHF / Congestive Heart Failure ☐ GERD / Reflux ☐ Hyperthyroid
☐ COPD / Emphysema ☐ Depression ☐ Hypothyroid
☐ Asthma ☐ Anxiety ☐ Seasonal Allergies
☐ Arthritis ☐ Osteoporosis ☐ Chronic Pain Syndrome
☐ Cancer *Type:* _____ *Type of Treatment:* Type of Treatment (select)
☐ Other significant illness or hospitalization. Explain: _____

Female Reproductive History

Date of FIRST menstrual period: _____ Date of last menstrual period: _____
Are you pregnant? ☐ Yes ☐ No Are you currently breast feeding? ☐ Yes ☐ No
Number of pregnancies: _____ Number of births: _____
Any complications during pregnancy? ☐ Yes ☐ No Type of complication: _____
Do you use birth control? ☐ Yes ☐ No What type of birth control? _____
Date of last pap smear? _____ ☐ Normal ☐ Abnormal: _____
Date of last mammogram: _____ ☐ Normal ☐ Abnormal: _____

Pediatric Patient Medical History

Birth history: ☐ Term birth ☐ Pre-term birth at _____ weeks
Pregnancy / birth complications: ☐ None ☐ _____
Immunizations: ☐ Up to date ☐ Missing: _____

Wellness Medical History

Immunizations:

☐	Influenza	Date of vaccination: _____	☐	Zostavax	Date of vaccination: _____
☐	Pneumonia	Date of vaccination: _____	☐	Prevnar	Date of vaccination: _____
☐	TDAP	Date of vaccination: _____	☐	Tetanus	Date of vaccination: _____

Wellness Exams:

Date of last colonoscopy: _____	☐	Normal	☐	Abnormal: _____
Date of last eye exam: _____	✔	Normal	☐	Abnormal: _____
Date of last fasting labs drawn: _____	☐	Normal	☐	Abnormal: _____
Date of last wellness physical exam: _____	☐	Normal	☐	Abnormal: _____

Personal Past Surgical History

Procedure: _____ Year: _____

Procedure: _____ Year: _____

Procedure: _____ Year: _____

Procedure: _____ Year: _____

Procedure: _____ Year: _____

Family Medical History

Father:	✔	Living	Age: _____	Significant medical history: _____
	☐	Deceased	Cause of death: _	_____
Mother:	✔	Living	Age: _____	Significant medical history: _____
	☐	Deceased	Cause of death: _	_____

Other significant family history (i.e., siblings or children with diabetes, cancer, etc.) _____

_____

Other Physician History

In the last 2 years, what other physicians have you regularly seen for medical care (i.e. a cardiologist, pain management, etc.)?

Physician Name: _____ Specialty: _____

Physician Name: _____ Specialty: _____

Physician Name: _____ Specialty: _____

Other Physician History

Current Prescription Medications:

Name: _____ Strength: _____ Directions: _____

Name: _____ Strength: _____ Directions: _____

Name: _____ Strength: _____ Directions: _____

Name: _____ Strength: _____ Directions: _____

Name: _____ Strength: _____ Directions: _____

Over the Counter Medications / Supplements / Vitamins:

☐ Aspirin 81mg ☐ Aspirin 325mg ☐ Multivitamin ☐ Calcium with Vitamin D

Name: _____ Strength: _____ Directions: _____

Name: _____ Strength: _____ Directions: _____

Name: _____ Strength: _____ Directions: _____

Additional Information / Additional Space

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Medical Records Release

Heidi Machen, APRN

Patient's Name: _____

Date of Birth: _____

From: _____
_____
_____
_____

To: Machen Family Medical
1995 Harrison Street
Batesville, AR 72501
Phone: (870) 262-8024

*Records to be released:

_____☐___ ALL medical records
_____☐___ Annual exam
_____☐___ Laboratory / Radiological reports
_____☐___ Other:

* I understand that my medical records are protected under state and federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections (including testing or treatment for HIV/AIDS), and diagnosis of mental illness or psychiatric care cannot be released without my written consent.

*Please initial below if you DO NOT want any of the following records released. Unless otherwise marked, all applicable records will be released. This consent can be revoked by me at any time unless action has been taken in reliance on it.

_____☐___ Drug and/or alcohol abuse, diagnosis or treatment
_____☐___ HIV/AIDS testing and/or treatment
_____☐___ Psychiatric care and/or mental illness
_____☐___ Confirmed sexually transmitted illness test results and/or treatment

_____
Signature of Patient or Responsible Party Date

_____
Witness Date

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Patient Name: _____

Address: _____

City, State, Zip: _____

Date of Birth: _____ Contact Number: _____

Records requested from:

_____

_____

_____

_____

_____

Records to use or disclose to:

Machen Family Medical

1995 Harrison Street

Batesville, AR 72501

Phone: (870) 262-8024

Records to be released:

☐ All records

or:

☐ Abstract ☐ Admission Record ☐ Clinic Record

☐ Discharge Summary ☐ ER Record ☐ History and Physical

☐ Nurse's Notes ☐ Operative Report ☐ Physician's Notes

☐ Other: _____

I do hereby consent and authorize Machen Family Medical to release copies of my medical records.

_____

Signature Date