HealthStar Physicians of Hot Springs, PLLC & HealthStar VA, PLLC
1661 Airport Road, Suite D
Hot Springs, AR 71913
Tel: (501) 625-7500
Fax: (501) 625-7777

Hamilton West Family Medicine
1629 Airport Road, Suite B
Hot Springs, AR 71913
Tel: (501) 767-0075
Fax: (501) 760-2739

West Gate Family Medicine
2266 Albert Pike Road
Hot Springs, AR 71913
Tel: (501) 767-1144
Fax: (501) 767-4455

Fountain Lake Family Medicine
4517 Park Avenue
Hot Springs, AR 71901
Tel: (501) 623-7900
Fax: (501) 623-7337

Glenwood Family Medicine
248 Highway 70 East
Glenwood, AR 71943
Tel: (870) 356-4801
Fax: (870) 356-5467

Lake Hamilton Family Medicine
1661 Airport Road, Suite F
Hot Springs, AR 71913
Tel: (501) 651-4300
Fax: (501) 547-5688

Lakeside Family Medicine
124 Hollywood AVE
Hot Springs, AR 71901
Tel: (501)624-0070
Fax: (501)624-8721

FirstCare Malvern School-Based Community Clinic
1517 S Main Street Malvern, AR 72104
Tel: (501)332-7525
Fax: (501)467-3071

First Care Family Health & Walk-in Clinic – Mena
1706 Highway 71 North
Mena, AR 71953
Tel: (479) 394-1500
Fax: (479) 394-1525

FirstCare Walk-In
120 Adcock Road, Suite A
Hot Springs, AR 71913
Tel: (501) 651-4500
Fax: (501) 651-4510

HealthStar House Calls
120 Adcock Road, Suite D
Hot Springs, AR 71913
Tel: (501) 547-5691
Fax: (501) 651-4296

August 19, 2020

RE: School Telehealth Services Available September 1, 2020

Dear Parent/Guardian:

We are excited about the opportunity to work with your child's school to provide acute care via telehealth during school hours. Telehealth (telemedicine) is the exchange of medical information from one site to another via electronic communications. The telehealth services offered to the school will allow students and staff to have a medical appointment with a licensed nurse practitioner or physician via interactive video equipment. As parents, you will be able to join the telehealth visit virtually as well if you have access to a smartphone, tablet or computer. If you and the nurse agree that your child should be seen by a telehealth provider, the nurse will send you a link to join the video session.

These telehealth visits will be for acute problems that may arise throughout the day. For any needs that cannot be resolved via telehealth by one of our on-call providers, we will refer you back to your child's primary care provider. If you do not have a primary care provider, we will be happy to see you or your child at our Malvern location.

Brittany Turner, CNP (certified nurse practitioner) will be the telehealth provider for Poyen School District. She works at our Malvern location with Dr. Larry Brashears so she is close by. Should your child need to be seen at a clinic and you do not currently have a physician that you see regularly, Brittany will be happy to see your child and the rest of your family. She treats adults and children. See flyer for more information on Brittany's background and our Malvern location.

Please review and complete the forms below to ensure we are providing your child with the highest quality medical care. **These forms may also be completed at https://www.healthstarphysicians.com/poyen-school-district.php**

Please return the packet to your child's school nurse at your earliest convenience. You may contact the school or our office with any questions you may have.

Respectfully,

Rachel Wallis, MPH
Chief Executive Officer
HealthStar Physicians of Hot Springs, PLLC

School-Based Telemedicine: What to Expect

Providers at HealthStar are working in partnership with the nurse within your school district to offer you telemedicine services.

What is Telemedicine?

Telemedicine is the exchange of medical information from one site to another via electronic communications. The Telemedicine services offered to you will allow you to have a medical appointment with a specialist via interactive video equipment. You will be able to speak in real-time with the specialist during your telemedicine appointment.

Is Telemedicine Safe?

Yes, all telemedicine sessions are safe, secure, encrypted and follow the same privacy (i.e. HIPAA) guidelines as traditional, in-person medical appointments. Your telemedicine appointments will always be kept confidential. In addition, telemedicine appointments are NEVER audio or video recorded.

Can I Choose Not to Participate?

Of course, with this program, you have been offered the option of seeing a HealthStar provider via secure and interactive video equipment within your school. It is your choice to use the services.

Things to Remember about Your Telemedicine Appointment:

1. The school nurse needs to be notified of an acute illness or injury
2. The school nurse will triage the situation and contact you for verbal consent prior to beginning the telemedicine visit.
3. If you have any questions before or after the session, you may ask your school nurse or contact our Malvern location at (501) 332-7525.
4. The Telemedicine New Patient Packet (included here) must be completed prior to initiating your first Telemedicine session. You must complete these forms in order to begin the telemedicine appointment:
   - Telemedicine Consent Form, Patient Information Form
   - The notice of privacy practices, patient rights, and responsibilities form and the Health Information Exchange (HIE) consent to viewing form.
5. If medications are prescribed by a HealthStar provider, you will be able to pick it up directly at your pharmacy of choice as the HealthStar provider will either phone in or electronically prescribe your medication(s).
6. If a prescription refill is needed, please call your pharmacy and have them send over a refill request. It will be processed within 1 business day.
7. If you have questions about care or medications, please don't hesitate to call us at (501) 332-7525.
8. If you have any questions or concerns after reading this form please contact us at (501) 332-7525.

School-Based Telehealth Program

The **Poyen School District** is proud to offer quality healthcare services that are easily accessible to the student body through our School-Based Telehealth Program. We want to ensure that our students are healthy so they can get the most out of their educational experience. We expect that students will miss less school because they can be seen early, preventatively, and treated quickly right here on campus.

The NEW SBTH parent consent form is a requirement to use medical services provided through Telehealth on our school campus. This form provides consent for the SBTH provider to offer medical care, preventative and educational services to your student. We strive to keep you informed about everything we are doing.

This is an example of how SBTH services may work. If the school nurse feels your child needs medical services, she will call you. If you want your child to be seen at school via telehealth *and we have the parent consent form on file*, then your child will be seen via telehealth in the presence of the school nurse in his/her office. If you are able, we welcome you to join the "virtual" clinic visit as well. The nurse can forward you the link to the online meeting space.

If we do not have the necessary forms on file and you want your child to be seen, you can choose to give verbal consent and complete these forms and return within one business day. This may require you coming to the school to complete the forms and establish care processes. We will not provide medical services to your child without having consent from you or another guardian.

If your child is covered under ARKids First and a HealthStar Provider (listed on the next page) is not their assigned Primary Care Provider (PCP), we will need to get a referral from their PCP before each telehealth visit. If you wish to switch your child over to a HealthStar PCP (not required), please complete the PCP Change Form in this packet and return to the School Nurse.

If your child is commercially insured, they may be seen by our provider via telehealth without a referral from their PCP.

If you have any questions, concerns, or feedback, please contact Jaci Austin at (501)332-8884 ext 1012 or Asa Chapman at (501)332-7525.

Don't forget to complete and INITIAL the SBTH parent consent form as it opens the door for any of the SBTH services.

Arkansas law (Ark. Code Ann.§ 20-9-602 (2012) and § 20-16-508 (2012) does not require consent for examination and treatment of STDs, examination and diagnosis of pregnancy, family planning services, substance abuse counseling and treatment, and behavioral health counseling and treatment.

FirstCare
MALVERN
SCHOOL-BASED COMMUNITY CLINIC

Telemedicine Provider

Brittany Turner, CNP

Brittany is a board-certified Family Nurse Practitioner. She attended Arkansas Tech University where she received a Bachelor of Science in Nursing. Brittany worked as a registered nurse for seven years before pursuing her Master of Science in Nursing at Chamberlain University. She works full time at FirstCare Malvern School-Based Community Clinic alongside Dr. Larry Brashears. Brittany will be Poyen's Telehealth Provider. She is accepting new patients of all ages.

FirstCare Malvern
School-Based Community Clinic

Monday-Thursday 7:30am - 4:30pm

Friday 7:30am - 12:00pm

(501)332-7525

1517 S Main Street
Malvern, AR 72104
www.healthstarphysicians.com

Poyen School District

HealthStar
PHYSICIANS OF HOT SPRINGS

Poyen School District
14296 HWY 270 West
Poyen, AR 72128
501-332-8884

PARENT CONSENT FORM*

Student Name: _____ DOB: _____ Grade: _____

Address (Street, Apt, City, State, Zip): _____

Phone #: _____ Alternate Phone #: _____

Current primary care physician (PCP): _____

I understand the following types of services are available through the _____School District's School-Based Telehealth Program by the Providers listed below. Please note that **YOU WILL BE CONTACTED PRIOR** to your child being seen at the clinic **for your specific instructions and guidelines.**

I give my consent for treatment *with prior notification* where *noted by MY INITIALS*:

_____ *initial* **Physical/Behavioral Health Services – HealthStar Physicians** of Hot Springs. Services to include, but are not limited to:

- Diagnosis and treatment of acute and chronic illnesses
- Treatment of minor injuries
- Health education, counseling, and wellness promotion
- Nutrition education and weight management
- Prescription medications
- Classroom presentations
- Referrals for services not provided

_____ *initial* **Transportation consent** I give my permission for the school to transport my child to any of these services with prior notification to me should the need arise. I understand that my child may be at greater risk of injury or death by being transported in a private vehicle instead of a school bus and assume such risk on behalf of my child. I agree not to hold Poyen School District or any of its agents or employees liable for any sum which I/we might claim as a result of injury, or property damage arising out of, or caused by any accident or occurrence during the time said student is being transported.

By signing below, I give my permission for the student listed above to receive treatment as noted by my initials through Poyen School District's Teleheath Program by the above Providers.

_____ _____

Parent / Guardian Signature **Date**

***Signed form remains valid while student is enrolled in Poyen School District or until rescinded in writing.**

REV. 08.14.2020

Locations & Providers

Clinic	Providers
Hamilton West Family Medicine 1629 Airport Road, Suite B Hot Springs, AR 71913 Tel: (501) 767-0075 Fax: (501) 760-2739	Kevin Hale, MD Jodi Sandson, MD Michael Mullins, MD Scott Erwin, MD Jon Robert, MD Pediatrician Courtney Huneycutt, CNP Pediatrics Miranda Edgar, CNP Michelle Auld, CNP Matthew Huskey, CNP Natalie Brown, CNP Gail Pruitt, RNP Amber Cross, LPC
West Gate Family Medicine 2266 Albert Pike Road Hot Springs, AR 71913 Tel: (501) 767-1144 Fax: (501) 767-4455	Amy Reeves, MD Barton Parish, MD Jessica Smith, MD Pediatrician Brittany Lacy, CNP Casey Powell, CNP Monica Brannon, LPC
Fountain Lake Family Medicine 4517 Park Avenue Hot Springs, AR 71901 Tel: (501) 623-7900 Fax: (501) 623-7337	Rick Finch, DO Greg Sketas, MD Alicia Ashley, CNP Julie Dickerson, LPC
Lakeside Family Medicine 124 Hollywood AVE Hot Springs, AR 71901 Tel: (501)624-0070 Fax: (501)624-8721	Ted Faro, DO Jamie Mullenix, MD James Humphreys, MD Julie Dickerson, LPC
Lake Hamilton Family Medicine 1661 Airport Road, Suite F Hot Springs, AR 71913 Tel: (501) 651-4300 Fax: (501) 547-5688	Janette Parchman, MD Hunter Carrington, MD Kayla Stanage, CNP
Glenwood Family Medicine 248 Highway 70 East Glenwood, AR 71943 Tel: (870) 356-4801 Fax: (870) 356-5467	Matthey Hulsey, DO Ellen Moreland, CNS Denise Patten, CNP Shawna Hellums, CNP Pediatrics Priscilla Faulkner, LPC
FirstCare Malvern School-Based 1517 S Main Street Malvern, AR 72104 Tel: (501)332-7525 Fax: (501)467-3071	Larry Brashears, MD Brittany Turner, CNP
FirstCare Walk-In 120 Adcock Road, Suite A Hot Springs, AR 71913 Tel: (501) 651-4500 Fax: (501) 651-4510	Troy Oxner, MD Stephanie Ragsdale, CNP Brent Fikes, CNP Stacy Reynolds, CNP
FirstCare Walk-In Mena 1706 Highway 71 North Mena, AR 71953 Tel: (479) 394-1500 Fax: (479) 394-1525	Kimberly Nance, CNP Anna Davis, CNP

SKIP THIS DOCUMENT IF YOU CURRENTLY HAVE AN ASSIGNED PCP AND DO NOT WANT TO SWITCH TO HEALTHSTAR. SWITCHING IS NOT REQUIRED TO PARTICIPATE IN TELEHEALTH PROGRAM.

ARKANSAS MEDICAID PRIMARY CARE PHYSICIAN MANAGED CARE PROGRAM
PRIMARY CARE PHYSICIAN SELECTION AND CHANGE FORM

Member Information:

First Name_____ Last Name_____ Middle Initial_____

Medicaid ID# _____ Social Security # _____

Birth Date (mm/dd/yyyy) _____

Mailing Address_____ City _____ State ____ Zip _____

Home Phone _____ Cell Phone_____

Email address _____

Requested New Doctor (Primary Care Provider):

I have picked the three (3) physicians named below in order of my preference to be my primary care physician. I understand only one (1) of them will be my primary care physician.

1. _____ _____ _____
   Doctors first and last name | Medicaid Provider ID# | Date of assignment

2. _____ _____ _____
   Doctors first and last name | Medicaid Provider ID# | Date of assignment

3. _____ _____ _____
   Doctors first and last name | Medicaid Provider ID# | Date of assignment

Reason for Request to Assign/Change Doctor (Primary Care Provider)
Choose all that apply. Select at least one.

- ☐ New Member – made 1st time selection
- ☐ Already patient with requested PCP
- ☐ Requested PCP already sees family member
- ☐ Member preference
- ☐ Member moved
- ☐ PCP hours didn't fit member need
- ☐ Quality of care
- ☐ Office wait times are too long
- ☐ Takes too long to get an appointment
- ☐ Office too far away/ hard to get to
- ☐ Language / communication barrier
- ☐ Other (please specify)_____

Signatures:

Member Signature (or Legal Guardian if a minor)_____

Printed Name of Member (or Legal Guardian if a minor) _____

Date (mm/dd/yyyy) _____

Telemedicine Consent Form

1. I authorize Poyen School to allow me/the patient to participate in a telemedicine (videoconferencing) service with HealthStar.

2. The type of services to be provided via telemedicine may include:
   - Diagnosis and treatment of acute and chronic illnesses
   - Treatment of minor injuries
   - Health education, counseling, and wellness promotion
   - Prescription medications
   - Nutrition education and weight management
   - Classroom presentations
   - Referrals for services not provided

3. I understand that this service is not the same as a direct patient/healthcare provider visit, because I/the patient will not be in the same room as the healthcare provider performing the service. I understand that parts of my/the patient's care and treatment which require physical tests or examinations may be conducted by the clinical staff at my/the patient's location under the direction of the telemedicine healthcare provider.

4. I have received a description of the nature and purpose of the videoconferencing technology and I am informed of expected risks, benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise during the telemedicine session, as well as possible alternatives to the proposed sessions, including visits with a physician in-person. I also understand the risks of not using telemedicine sessions. I have been given an opportunity to ask questions, and all my questions have been answered fully and satisfactorily.

5. I understand that there are potential risks to the use of this technology, including but not limited to interruptions, unauthorized access by third parties, and technical difficulties. I am aware that either my/the patient's healthcare provider or I can discontinue the telemedicine service if we believe that the environment and/or secure video connections are not adequate for the situation.

6. I understand that the telemedicine session will not be audio or video recorded at any time.

7. I agree to permit my/the patient's healthcare information to be shared with other individuals (eg School Nurse/Staff) for the purpose of scheduling and billing. I agree to permit individuals (eg School Nurse/Staff) other than my/the patient's healthcare provider and the remote healthcare provider to be present during my/the patient's telemedicine service to operate the video equipment. I further understand that I will be informed of their presence during the telemedicine services. I acknowledge that if safety concerns mandate additional persons to be present, then my/guardian permission may not be needed.

8. I acknowledge that I have the right to request the following:
   - The omission of specific details of my/the patient's medical history/physical examination that is personally sensitive, or
   - Termination of the service at any time.

9. When the telemedicine service is being used during an emergency, I understand that it is the responsibility of the telemedicine provider to advise my/the patient's local healthcare provider regarding necessary care and treatment.

10. It is the responsibility of the telemedicine provider to conclude the service upon the termination of the videoconference connection.

11. I/the patient understand(s) that my/the patient's insurance will be billed by the telemedicine healthcare provider for telemedicine services. A cash price for telemedicine services is available. Please contact our business office for more details at 501-625-7500.
12. My/the patient's consent to participate in this telemedicine service for the duration of the specific service identified above, or until I revoke my consent in writing.
13. I/the patient agree that there have been no guarantees or assurances made about the results of this service.
14. I confirm that I have read and fully understand both the above and the Telemedicine: What to Expect Form provided. All blank spaces have been completed prior to my signing.

** The signature of the patient must be obtained unless the patient is a minor unable to give consent or otherwise lacks capacity.*

_____ _____

Patient First Name Patient Last Name

_____ _____ _____

Patient Date of Birth Parent/Relative/Guardian Name Signature

_____ _____

Relationship to Patient (If Required) Today's Date

_____

Interpreter's Name/Signature (If Required)

NOTE: THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD

To be completed by school nurse:

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment) the proposed program/procedure, have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

_____ _____

Telemedicine School Nurse Facilitator Date

HealthStar
PHYSICIANS OF HOT SPRINGS

PATIENT REGISTRATION FORM

LAST NAME: _____
FIRST NAME: _____
PREFERRED NAME: _____
MIDDLE NAME, SUFFIX: _____
PREVIOUS NAME: LAST: _____, FIRST _____
SEX: _____ MALE _____ FEMALE
DATE OF BIRTH: MM _____ DD _____ YYYY _____
SOCIAL SECURITY NUMBER: _____
ADDRESS: _____
ADDRESS: _____
ZIP CODE: _____
CITY: _____
STATE: _____

HOME PHONE: _____ MOBILE PHONE: _____
CONSENT TO TEXT: _____YES _____ NO WORK PHONE: _____
PREFERRED PHARMACY:_____
PRIMARY INSURANCE: _____
INSURANCE ID # _____ GROUP # _____
POLICY HOLDER NAME: _____ POLICY HOLDER DOB: _____
EMAIL: _____
CONTACT PREFERENCE: ____ HOME PHONE ____ MOBILE PHONE ____ WORK PHONE

LANGUAGE: ____ ENGLISH _____ SPANISH _____ OTHER

RACE: ___ BLACK OR AFRICAN AMERICAN ___AMERICAN INDIAN OR ALASKA NATIVE
___ WHITE ___ ASIAN ___ NATIVE HAWAIIAN ___ OTHER ___ DECLINED

ETHNICITY: ___ HISPANIC OR LATINO ___ NOT HISPANIC OR LATINO ___ OTHER ___ DECLINED

MARITAL STATUS: ___ MARRIED ___ SINGLE ___ DIVORCED ___ WIDOWED ___ PARTNER

GUARDIAN: LAST NAME: _____
FIRST NAME: _____
MIDDLE NAME, SUFFIX _____

EMERGENCY CONTACT: NAME_____
RELATIONSHIP: ___ SPOUSE ___ PARENT ___ CHILD ___ SIBLING
___ FRIEND ___ COUSIN ___ GUARDIAN ___ OTHER
HOME PHONE: _____
MOBILE PHONE: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize release of any information concerning me or my child's healthcare, advice or treatment used for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the Doctor.

_____ _____
SIGNATURE OF PATIENT OR GUARDIAN TODAY'S DATE

HealthStar
PHYSICIANS OF HOT SPRINGS

PATIENT HISTORY FORM

(Please fill in as much as possible)

Patient Name: _____ **Date of Birth:** _____ **Height:** _____ **Weight:** _____

Reason for visit today: _____

Previous PCP and Specialists (list any primary care or specialists, such as cardiology, orthopedics, pulmonary, etc):

List all drug and non-drug allergies: _____

List all current prescription medications:

Name	Dose (mg)	How Often	Name	Dose (mg)	How Often

List all current and past medical conditions:

List all past surgeries and procedures:

Date:	Specify type of surgery and body location:	Performing physician:

List any family medical history:

Father: _____ Paternal Grandfather: _____
Mother: _____ Paternal Grandmother: _____
Brother: _____ Maternal Grandfather: _____
Sister: _____ Maternal Grandmother: _____

Personal History:

Do you smoke? Yes or No How much per day? _____ For how long? _____ Quit date? _____
Do you use smokless tobacco? Yes or No How much per day? _____ For how long? _____
Do you drink alcohol? Yes or No How often? _____ Type of alcohol _____
Have you ever tested positive for any STD's or communicable diseases? _____ If yes, list _____
Do you have any history of substance use or abuse? Yes or No If yes, list _____

(All of the above information is to enable us to provide you with better healthcare. It is part of your private medical record and is not shared with anyone without your express permission.)

Marital Status: _____ Any children & how many? _____

Are you currently employed? _____ What type of work and where? _____

HealthStar
PHYSICIANS OF HOT SPRINGS

SOCIAL NEEDS SCREENING

What is your housing situation today?

- ☐ I have housing
- ☐ I do not have housing (staying with others; in a hotel, shelter, or car; or outside)
- ☐ I choose not to answer

Are you worried about losing your housing?

- ☐ Yes
- ☐ No
- ☐ I choose not to answer

What is your current work situation?

- ☐ Full time work
- ☐ Part time or temporary work
- ☐ Unemployed and seeking work
- ☐ Unemployed but not seeking work
- ☐ I choose not to answer

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.

☐ Yes	☐ No	**Food**
☐ Yes	☐ No	**Clothing**
☐ Yes	☐ No	**Utilities**
☐ Yes	☐ No	**Child Care**
☐ Yes	☐ No	**Medicine or any health care** (medical, dental, mental, vision)
☐ Yes	☐ No	**Phone**
☐ Yes	☐ No	**Other** (Please write)

☐ I choose not to answer

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

☐ Yes ☐ No ☐ I choose not to answer

How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

☐ Less than once a week ☐ 1 or 2 times a week ☐ 3 to 5 times a week

☐ More than 5 times a week ☐ I choose not to answer

Do you feel physically and emotionally safe where you currently live?

☐ Yes ☐ No ☐ I choose not to answer

In the past year, have you been afraid of your partner or ex-partner?

☐ Yes ☐ No ☐ Unsure ☐ I have not had a partner ☐ I choose not to answer

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.

About This Notice

We are required by law to maintain the privacy of Protected Health Information (PHI) and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your PHI, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information (PHI)?

Protected Health Information (PHI) is information that individually identifies you and that we create or get from you or from another health care provider, a health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your PHI

We may use and disclose your PHI in the following circumstances:

For Treatment. We may use PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel who are involved in taking care of you, including people outside our practice, such as referring or specialist physicians.

For Payment. We may use and disclose PHI so that we can bill for the treatment and services you get from us and can collect payment from you, an insurance company, or another third party. For example, we may need to give your health plan information about your treatment in order for your health plan to pay for that treatment. We also may tell your health plan about a treatment you are going to receive to find out if your plan will cover the treatment. If a bill is overdue we may need to give PHI to a collection agency to the extent necessary to help collect the bill, and we may disclose an outstanding debt to credit reporting agencies.

For Health Care Operations. We may use and disclose PHI for our health care operations. For example, we may use PHI for our general business management activities, for checking on the performance of our staff in caring for you, for our cost-management activities, for audits, or to get legal services. We may give PHI to other health care entities for their health care operations, for example, to your health insurer for its quality review purposes.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

Minors. We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Personal Representative. If you have a personal representative, such as a legal guardian (or an executor or administrator of your estate after your death), we will treat that person as if that person is you with respect to disclosures of your PHI.

As Required by Law. We will disclose PHI about you when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclosure the information to someone who may be able to help prevent the threat.

Business Associates. We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy of your PHI.

Organ and Tissue Donation. If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release PHI as required by military command authorities. We also may release PHI to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (8) the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves if you sue us.

Law Enforcement. We may release PHI if asked by a law enforcement official for the following reasons: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

National Security. We may release PHI to authorized federal officials for national security activities authorized by law. For example, we may disclose PHI to those officials so they may protect the President.

Coroners, Medical Examiners, and Funeral Directors. We may release PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

Individuals Involved in Your Care or Payment for Your Care. We may disclose PHI to a person who is involved in your medical care or helps pay for your care, such as a family member or friend, to the extent it is relevant to that person's involvement in your care or payment related to your care. We will provide you with an opportunity to object to and opt out of such a disclosure whenever we practicably can do so.

Disaster Relief. We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Your Written Authorization is Required for Other Uses and Disclosures

Uses and disclosures for marketing purposes and disclosures that constitute a sale of PHI can only be made with your written authorization. Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. Disclosures that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Special Protections for HIV, Alcohol and Substance Abuse, Mental Health, and Genetic Information

Special privacy protections apply to HIV-related information, alcohol and substance abuse, mental health, and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these kinds of PHI. Please check with our Privacy Officer for information about the special protections that do apply. For example, if we give you a test to determine if you have been exposed to HIV, we will not disclose the fact that you have taken the test to anyone without your written consent unless otherwise required by law.

Your Rights Regarding Your PHI

You have the following rights, subject to certain limitations, regarding your PHI:

Right to Inspect and Copy. You have the right to inspect and/or receive a copy of PHI that may be used to make decisions about your care or payment for your care. But you do not have a right to inspect or copy psychotherapy notes. We may charge you a fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your PHI is maintained in one or more designated record sets electronically (for example an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We may charge you a reasonable, cost-based fee for the labor associated with copying or transmitting the electronic PHI. If you chose to have your PHI transmitted electronically, you will need to provide a written request to this office listing the contact information of the individual or entity who should receive your electronic PHI.

Right to Receive Notice of a Breach. We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breach of your Unsecured PHI.

Right to Request Amendments. If you feel that PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) was not created by us, (2) is not part of the medical information kept by or for us, (3) is not information that you would be permitted to inspect and copy, or (2) is accurate and complete. If we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.

Right to an Accounting of Disclosures. You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your PHI. We are not required to list certain disclosures, including (1) disclosures made for treatment, payment, and health care operations purposes, (2) disclosures made with your authorization, (3) disclosures made to create a limited data set, and (4) disclosures made directly to you. You must submit your request in writing to our Privacy Officer. Your request must state a time period which may not be longer than 6 years before your request. Your request should indicate in what form you would like the accounting (for example, on paper or by e-mail). The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we agree, we will comply with your request unless we terminate our agreement or the information is needed to provide you with emergency treatment.

Right to Restrict Certain Disclosures to Your Health Plan. You have the right to restrict certain disclosures of PHI to a health plan if the disclosure is for payment or health care operations and pertains to a health care item or service for which you have paid out of pocket in full. We will honor this request unless we are otherwise required by law to disclose this information. This request must be made at the time of service.

Right to Request Confidential Communications. You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a special address or call you only at your work number. Your must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

The effective date of the Notice is stated at the beginning. We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

Optional Provisions to be included as applicable:

Foreign Language Version. If you have difficulty reading or understanding English, you may request a copy of this Notice in Spanish.
[Note: Foreign language versions are not required by HIPAA, but federal law requires a provider to make material distributed to the public, such as a Notice of Privacy Practices, available in the languages of persons with limited English proficiency in the provider's service area.]

Medical Residents and Medical Students. Medical residents or medical students may observe or participate in your treatment or use your PHI to assist in their training. You have the right to refuse to be examined, observed, or treated by medical residents or medical students.

Newsletters and Other Communications. We may use your PHI to communicate to you by newsletters, mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.

Psychotherapy Notes. Under most circumstances, without your written authorization we may not disclose the notes a mental health professional took during a counseling session. However, we may disclose such notes for treatment and payment purposes, for state and federal oversight of the mental health professional, for the purposes of medical examiners and coroners, to avert a serious threat to health or safety, or as otherwise authorized by law.

Research. We may use and disclose your PHI for research purposes, but we will only do that if the research has been specially approved by an institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. But we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the security of the data, and (3) not identify the information or use it to contact any individual.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer:	Kim Sandifer
Mailing Address:	1661 Airport Rd, Suite F Hot Springs, AR 71913
Telephone:	501-651-4300
E-mail:	ksandifer@healthstarphysicians.com

HealthStar
PHYSICIANS OF HOT SPRINGS

1661 Airport Rd, Ste D, Hot Springs, AR 71913

HEALTHSTAR PHYSICIANS OF HOT SPRINGS, LLC

Notice of Privacy

Hamilton West Family Medicine
1629 Airport Rd, Ste B
Hot Springs, AR 71913

Glenwood Family Medicine
248 Hwy 70 East, Ste A
Glenwood, AR 71943

West Gate Family Medicine
2266 Albert Pike Road
Hot Springs, AR 71913

Fountain Lake Family Medicine
4517 Park Avenue
Hot Springs, AR 71901

First Care Family Medicine Mena
1706 North US 71
Mena, AR 71953

HealthStar Therapy Services
1661 Airport Rd, Ste A
Hot Springs, AR 71913

Lake Hamilton Family Medicine
1661 Air port Rd, Ste F
Hot Springs, AR 71913

Lakeside Family Medicine
124 Hollywood Avenue
Hot Springs, AR 71901

FirstCare Walk-in Clinic
120 Adcock Rd, Suite A
Hot Springs, AR 71913

Dr. John Pace's Office
120 Adcock Rd, Suite C
Hot Springs, AR 71913

HEALTHSTAR PHYSICIANS

"DEDICATED TO QUALITY HEALTHCARE"

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGMENT

I, _____, have received a copy of
(PLEASE PRINT YOUR NAME ABOVE)
The HealthStar Physicians of Hot Springs Notice of Privacy Practices.

_____ _____
Signature of Patient or Legal Guardian Date

FOR OFFICE USE ONLY

PATIENT WAS OFFERED THE HIPAA PRIVACY NOTICE:

_____ Refused _____ Accepted

Patient Account Number: _____ Employee's Initials: _____

Notes: _____

_____

HEALTHSTAR PHYSICIANS OF HOT SPRINGS

"DEDICATED TO QUALITY HEALTHCARE"

HEALTHSTAR PHYSICIANS OF HOT SPRINGS HIPAA
Acknowledgement of Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information or PHI about you and or your family member. The Notice contains a Patient Rights section describing your rights under the Health Information Portability and Accountability Act or HIPAA. You have the right to review our Notice before signing this acknowledgement. The terms of our Notice may change. If we change our Notice, you will be given a revised copy on your first visit to our office following the date of the revision.

Individuals Involved in Your Care or Payment for Your Care
We may disclose Protected Health Information to a person who is involved in your medical care or helps pay for your care, such as a family member or friend. But before we do that, we will provide you with an opportunity to object to and opt out of such a disclosure whenever we practicably can do so. If you would like to give us permission to speak to certain individuals, you may do so by listing them below. Please understand that it is your responsibility to update this information.

You may discuss my medical care or payment of my medical care with:

_____ Relationship _____ Telephone# _____

_____ Relationship _____ Telephone# _____

_____ Relationship _____ Telephone# _____

This consent was signed by: _____

_____ _____
Print Name (Patient or Patient Representative) Date

Relationship to Patient: _____

PATIENT WAS OFFERED THE HIPAA NOTICE PRIVACY FORM:

_____ Refused _____ Accepted

HealthStar Physicians of Hot Springs

1661 Airport Rd, Suite D
Hot Springs, AR 71913
Phone: 501-625-7500

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask any questions you may have, and sign in the space provided. A copy will be provided upon your request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service, unless prior arrangements have been made. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, all services, including medication refills, will be discontinued for you and your immediate family, and your account will be turned over to a collection agency.

8. **No Insurance/Self Pay.** Please note that if you do not have insurance or have a large deductible not met when you come to the clinic, **payment is due at the time of service**.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

My signature below confirms that I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party **Date**

My signature below confirms that I have received and read a copy of the HIPAA Notice of Privacy Practices.

_____ _____

Signature of patient or responsible party **Date**

HealthStar Physicians of Hot Springs
Medication Policy

Please be advised that if you are on any of the following medications or are on a pain contract, or pain management from another physician, you must continue to receive your medication from that physician. **Our office WILL NOT routinely prescribe these medications.** We want to be upfront with you regarding this so that we can eliminate any confusion. There may be other medications not listed below that may also be included in this policy. This will be at the discretion of your provider.

BRAND NAME	GENERIC NAME
Xanax, Vallum, Ativan	Alprazolam, Diazepam, Lorazepam
Anexsia, Bencap HC, Ceta-Plus, Co-Gesic, Doiacet, Dolagesic, Dolorex, Forte, Duocet, Hy-Phen, Hydrocet, Hydrogesic, Lorcet, Lorcet HD, Lorcet Plus, Lortab, Margesic-H, Norco, Panacet, Polygesic, Stagesic, T-Gesic, Ugesic, Vanacet, Vicodin, Vicodin ES, Vicodin HP, Zydone	Hydrocodone
M-Oxy, OxyContin, Oxyfast, OxyIR, Percolone, Roxicodone, Endocet, Percocet, Roxicet, Rolilox, Tylox	Oxycodone
Mephergan	Meperdine
Astramorph PF, DepoDur, Duramorph, Infumorph, Kadian, Morphesian, MS Contin, MSIR, Oramorph, Roxanol, Roxanol 100	Morphine
Rela, Soma	Carisoprodol

If you have any questions, feel free to ask your provider.

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN **TODAY'S DATE**