LEOPARD CARE CLINIC

In Partnership With

Dr. Randy Walker

2020 - 2021 Student Registration Packet

Leopard Care Clinic supports student success because healthy students are better learners!

Patient Registration

First Name: _____ Last Name:_____ Middle Initial: _____

Patient Information:

Mailing Address:_____

City: _____ State: _____ Zip: _____

DOB: _____ Age: _____ Sex: _____ Race: _____

Home Phone: _____ Cell Phone:_____

Email: _____

Pharmacy of choice: _____

Phone: _____

Parent/Guardian Information:

First Name:_____ Last Name: _____ Middle Initial: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home/Cell Phone: _____ Work Phone:_____

Email: _____ DOB: _____ Last 4 of SS#: _____

Insurance Information:

ARKIDS/Medicaid # _____ or Member ID # _____

Group # _____ Insurance Company Name: _____

Company Address: _____ City: _____

State: _____ Zip: _____ Company Phone #: _____

Policy Holder Name: _____ Social Security #: _____

Policy Holder DOB: _____ Relationship to Insured: o Self o Spouse o Child o Other

Randy D. Walker MD PLLC,

CONSENT FOR TREATMENT:

I do hereby consent to out-patient care at any of the Randy D. Walker MD PLLC sites, encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to , routine laboratory work, such as blood, urine, and other studies, taking x-rays, heart tracing, and administration of medications prescribed by the physician or nurse practitioner.

PARENT/PATIENT INITIALS: _____

CONFIDENTIALITY POLICY:

All information obtained from you will be kept by all Randy D. Walker MD PLLC employees in strict confidence.

PARENT/PATIENT INITIALS: _____

RELEASE OF INFORMATION:

I hereby authorize the clinic to release medical information to any insurance carrier, including Medicare, Medicaid, all third party insurance carriers, and Workers Comp for the purpose of filing insurance claims.

PARENT/PATIENT INITIALS: _____

ACKNOWLEDGEMENT:

I acknowledge I am responsible to pay for any care according to the fees established.
I understand my medical claims are being filed as a courtesy and the ultimate responsibility, regardless of insurance coverage is mine. Furthermore, I authorize and assign benefits for this medical care paid to Randy D. Walker MD PLLC.

PARENT/PATIENT INITIALS: _____

Discounted SERVICES: (please choose only ONE option)

I have been offered the opportunity to participate in the discounted fee program; At this point, I do not wish to share my family's financial information.

I have accepted the offer to participate in the discounted fee program and willingly provide my family's financial information, please see verification information.

PARENT/PATIENT INITIALS: _____

Patient's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Medical History

Patient Name: _____ Date of Birth:_____

Who is your primary care physician_____

If you answer yes for any of the following questions, please explain on the provided line.

Have you ever been hospitalized or had a major operation? O Yes O No

_____

Are you taking any medications? O Yes O No

_____

Do you use tobacco products? O Yes O No

_____

Are you allergic to any medications or food? O Yes O No

_____

Do you use controlled substance? O Yes O No

_____

Have you ever had any serious illness or hospitalizations not listed above? O Yes O No

_____

Do you or have you had any of the following?

AIDS/HIV O Yes O No	**Diabetes O Yes O No**	**Hypoglycemia O Yes O No**
Anemia O Yes O No	**Epilepsy/Seizures O Yes O No**	**Hyperglycemia O Yes O No**
Breathing Problems O Yes O No	**Frequent Headache O Yes O No**	**Stomach Problems O Yes O No**
Artificial Joint O Yes O No	**Frequent Cough O Yes O No**	**Lung Disease O Yes O No**
Asthma O Yes O No	**Frequent Diarrhea O Yes O No**	**Psychiatric Care O Yes O No**
Blood Disease O Yes O No	**Fainting/ Dizziness O Yes O No**	**Sickle Cell O Yes O No**
Ulcers O Yes O No	**Hay Fever O Yes O No**	**Kidney Problems O Yes O No**
Bruise Easily O Yes O No	**Heart Murmur O Yes O No**	**Tonsillitis O Yes O No**
Cancer O Yes O No	**Hepatitis A O Yes O No**	**Tuberculosis O Yes O No**
Hives O Yes O No	**Hepatitis B or C O Yes O No**	**Tumors O Yes O No**
Congenital Heat Disorder O Yes O No	**Cold Sores/Fever Blisters O Yes O No**	**Artificial Heart Valve O Yes O No**

Comments:

To the best of my knowledge the questions on this form have been accurately answered. I understand that incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the providers of any changes.

_____ _____

Date Signature of Patient/Guardian

Family History

_____ _____

Patient Name Date of Birth

Please check the appropriate areas.

	Siblings	Mother	Father	Mother's	Father's
Alcoholism					
Asthma, Lung Disease					
Bleeding Disorder					
Cancer					
Diabetes					
Drug Abuse					
Epilepsy, Seizure Disorder					
Heart Disease					
Mental Illness, Depression, Anxiety, ADHD, etc….					
Migraines					
Thyroid Disease					
Other (specify)					

Please list any other information that you feel is pertinent to your or your child's health care:

_____

_____

_____

_____

_____

_____

Parents/Guardians/Patient:

Please read the following statements, sign, and return to the Leopard Care Clinic.

- I understand the following types of services are offered through Leopard Care Clinic:
    - Routine physical exams including well-child checks and sports physicals
    - Diagnosis and treatment of acute and chronic illness
    - Treatment of minor injuries
    - Referrals for services not provided by Leopard Care Clinic
    - Age appropriate reproductive health services with parental approval (abstinence counseling, education, exams, and referrals)*
    - Immunizations
    - Laboratory tests
    - Classroom presentations
    - Vision, hearing, dental, and blood pressure screenings
    - Health education, counseling, and wellness promotion
    - Prescription medications
- I give my permission for my child to receive medical care, illness prevention, wellness promotion programs, and/or behavioral health counseling services from the following providers at Leopard Care Clinic to the student named above**
- I understand this consent is good from the date listed below until my child graduates or moves out of the school district. I also understand if I would like to discontinue using any of the services that my child is enrolled in through Leopard Care Clinic, I must submit that request in writing to the Leopard Care Clinic office.
- I understand that information may be shared with the school nurse and my primary care physician or other chosen providers when pertinent to my child's health and also authorize the school nurse and primary care physician or other chosen providers to share information with Leopard Care Clinic when pertinent to my child's health.

The information given to this office pertaining to my child, _____, is truthful and complete to the best of my knowledge. I authorize the Health Care providers of Leopard Care Clinic to administer such procedures and treatment as they deem, necessary, **in my absence**, at Leopard Care Clinic to this child that is a ward in my legal custody. Leopard Care Clinic providers have implied no guarantee of cure. I understand it is my responsibility to update any changes to contact information, insurance information, or pharmacy selections to Leopard Care Clinic.

Assignment of Benefits and Authorization to Release Records

- I have been notified by the offices or providers for Leopard Care Clinic and/or Randy D Walker MD PLLC of their Privacy Practices for Protected Health Information and agree to the use of my PHI to carry out treatment, payment, and healthcare operations. I also agree to comply with the provider's HIPAA policy and Leopard Care Clinic's Grievance procedure. Full copies of the above policies or procedures can be provided upon request from the providers or Leopard Care Clinic staff.
- I authorize the offices or providers for Leopard Care Clinic and/or Randy D Walker MD PLLC to file an insurance claim for services provided through Leopard Care Clinic and accept full financial responsibility for the services rendered.

By signing below, I am stating that I have read and understand the information provided.

Responsible Party Printed Name	**Date**
Responsible Party Signature	**Date**
Student's/Employee's Name	**Date**

*** Arkansas law does not require parental consent for examination and treatment of STDs, examination and diagnosis of pregnancy, family planning services, substance abuse counseling and treatment, and behavioral counseling and treatment.**

**** All parental consents must be accompanied by a completed registration form and health history form.**