PILLOW CLINIC PLLC

DATE:_____

PATIENT INFORMATION

Patient Name: First_____MI_____ Last_____ SS# _____

DOB:_____ Sex: □ M □ F Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated □ Life Partner

Parent / Legal Guardian Name if patient is a minor Name_____ DOB_____

Race: □ White □ Black/African American □ Asian □ American Indian/Alaska Native □ Native Hawaiian/Pacific Islander □ Declined
Ethnicity: □ Not Hispanic/Latino □ Hispanic/Latino □ Declined

Preferred Language: English_____ Spanish_____ Vietnamese _____ Other_____

Address: _____Apt # _____ City_____St_____Zip _____

Phone: Home_____Cell_____ Work_____

E-Mail_____

Best Contact Method: □ Home □ Cell □ Work □ E-Mail □ Mail

OK TO LEAVE TEST RESULTS ON VOICEMAIL? _____ YES _____ NO

CAN WE TEXT YOU _____YES _____NO

FINANCIALLY RESPONSIBLE PARTY

☐ **Same as Patient Information** *(If different, please complete section below)*

Name: First_____MI_____ Last_____

Relationship: Spouse Parent Guardian Other (Please Specify): _____

Address: _____Apt #_____ City_____St_____Zip _____

Phone: Home_____ Cell_____ Work_____

Email Address _____

EMERGENCY NOTIFICATION

Name: _____ Relationship to Patient: _____

Phone: Home_____ Cell_____ Work_____

Name: _____ Relationship to Patient: _____

Phone: Home_____ Cell_____ Work_____

MEDICATION REFILL

Refill authorizations may require 48-72 hours. The best way to request refills is through your patient portal. Please allow sufficient time for us to process your refill request. Controlled drug prescriptions must be picked up in the office.

Pharmacy Name/Location_____ Phone_____

_____

Patient's Signature (Required)

OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO OTHERS

☐ **Do Not Release Information**

I authorize **PILLOW CLINIC PLLC** to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, billing information and/or medical care. This authorization will remain in effect until I provide written notification to **PILLOW CLINIC PLLC** of any changes or updates. I authorize **PILLOW CLINIC PLLC** to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care.

Name _____ Relationship_____ Phone_____

Name _____ Relationship_____Phone_____

FINANCIAL AND PAYMENT GUIDELINES

Notice: Our office does NOT file Auto Insurance claims for visits relating to motor vehicle accidents however a fee of $125 will be charged to the patient at the time of visit regardless of insurance coverage

NOTICE: Our office does NOT take appointments for workers compensation.

Payment is due at the time of service. This includes all co-pays, deductibles and co-insurance. If your insurance company requires a referral, it is the patient's responsibility (or guarantor) to obtain the referral prior to your appointment.

I authorize direct payment of my insurance benefits to **PILLOW CLINIC PLLC** for services rendered to myself or dependents.

Insurance will be filed for services rendered. Any charges for services not covered by insurance will be the responsibility of the patient or his/her guardian. I understand that it is my responsibility to know my insurance benefits and whether or not the services rendered are covered benefits.

Patient or guardian is responsible for notifying our office of any changes to demographics or insurance and billing information. Out of

Network services not paid by the health insurance company will be the responsibility of the patient or his/her guardian.

PILLOW CLINIC PLLC or its authorized agent will provide medical information to the insurance company as required for payment of claims for services rendered. ****If you are sent to a collection agency by us you will have to pay $100 before you can be seen.****

CONSENT FOR TREATMENT, RELEASE OF INFORMATION, OFFICE POLICIES & AUTHORIZATION OF BENEFITS:

Return phone calls: as our nurses see numerous patients during clinic hours, it is very difficult for them to return phone calls. We ask that you allow up to 24 hours for us to return your phone calls. If you have a life threatening situation please contact the emergency room for immediate assistance.

Late arrivals: patients that arrive late for their scheduled appointment will be seen as soon as possible. However, should another patient with a scheduled appointment arrive at the same time, they will be seen first. If you arrive more than 20 minutes late you will be asked to reschedule.

I consent to treatment necessary to the care which has been discussed and directed by the provider.

I authorize the release of all medical records to specialists and/or consulting physicians if applicable to my care and condition.

I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment.

I further authorize and request that insurance payments be directed to PILLOW CLINIC PLLC

I hereby give my consent to PILLOW CLINIC PLLC, including its licensed-practitioners and employees, to access, use, and disclose any protected health information to any pharmacies I currently use or will use in the future for the purpose of transmitting prescriptions to them for my treatment. I consent to the disclosure of my prescription medication information by any provider, mental health provider, pharmacy, insurer, or prescription benefits manager, specifically including any state or federal health program to PILLOW CLINIC PLLC, and pharmacies for the purpose of my treatment. My consent includes the re-disclosure of protected health information maintained by a drug or alcohol treatment program.

I have read, fully understand and agree to the above **medication refill guidelines, financial responsibility statement, payment guidelines, consent for treatment** and **release of medical information & Insurance authorization.** I also certify that all of the information, provided is complete and accurate.

Patient Name _____ Signature _____ Date_____

PATIENT MEDICAL HISTORY

Please describe any CURRENT medical problems:_____

_____

_____

_____

Please describe any PAST illnesses or injuries:_____

_____

_____

_____

Any Allergies to Medications:_____

_____

Smoker: YES or NO **Date Quit:**

Alcohol Consumption: YES or NO **How Often:**

Recreational Drug Use: YES or NO **Please describe:**

CURRENT MEDICATIONS

MEDICATION	DOSAGE	DIRECTIONS	NOTES

Please use back of form to add any additional medications or medical history.

PILLOW CLINIC

Social Determinates of Health Screening Questionnaire

Please take a moment to complete the following questions.

**ALL responses will be kept confidential and shared only with your medical team in effort to better your care

1. What is your living situation today?
    - I have a steady place to live
    - I have a place to stay TODAY, but I am worried about the future
    - I do NOT have a pace to stay, I am currently staying with others(Shelter, Hotel, Family, etc.)
2. Within the past 12 months, you were worried your food would run out before you would be able to purchase more?
    - Always
    - Sometimes
    - Never
3. In the past 12 months, has the lack of transportation kept you from being able to keep doctors appointments, work, or from getting things for daily living?
    - Always
    - Sometimes
    - Never
4. How often in the past 6 months has someone, including family and friends, physically hurt you?
    - Always
    - Sometimes
    - Never
5. How often do you feel lonely or isolated from those around you?
    - Always
    - Sometimes
    - Never
6. If for any reason, you need help with daily tasks(such as bathing, meal prepping and preparation, grocery shopping, etc.) do you get the help you need?
    - Always
    - Sometimes
    - Never

101 Shirley Hicks Drive
Helena, Arkansas 72342

DISCRIMINATION IS AGAINST THE LAW

Pillow Clinic, PLLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Pillow Clinic, PLLC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Pillow Clinic, PLLC provides free aids and services to people with disabilities to communicate effectively with us, such as:

- qualified sign language interpreters
- written information in other formats (large print, audio, accessible electronic formats, other formats)

provides free language services to people whose primary language is not English, such as:

- qualified interpreters
- information written in other languages

If you need these services, contact Tara Adams

If you believe that Pillow Clinic, PLLC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Tara Adams 101 Shirley Hicks Dr

Helena AR 72342 870-572-5996 TTY

870-572-4471 tadams@pillowclinic.net

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Tara Adams is available to help you.

You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- Electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at

  U.S. Department of Health and Human Services
  200 Independence Ave. SW
  Room 509F HHH Building
  Washington, DC 20201

- By phone at 1-800-368-1019; 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Pilllow Clinic PLLC

NOTICE OF PRIVACY PRACTICES

Effective Date: 02/10/2026.
This Notice was most recently revised on 02/05/2026.

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

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

Privacy Officer: Tara Adams
Mailing Address: 101 Shirley Hicks Dr Helena, AR 72342
Telephone: 870-572-5996
Fax: 870-572-4471
E-mail: tadams@pillowclinic.net

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 regarding 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, 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.

If we receive or keep information about you from a substance use disorder treatment program covered by 42 CFR Part 2 (called a "Part 2 Program") through a general consent you gave that program for treatment, payment, and/or health care operations, we may use and share your record for those same purposes as explained in this Notice, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against you. We will never use or share your Part 2 Program record, or any testimony about what is in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceeding by any federal, state, or local authority against you, unless you give written permission or a court issues an order after notifying you.

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 choose 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 <u>not</u> 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. You 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 for 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. You can get a copy of this Notice at our website: http://www.pillowclinicpllc.com.

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.

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.