



# HOUSEHOLD ASSESSMENT

(ONLY for patients requesting discounted services)

ARcare/ KentuckyCare /MississippiCare offer a discounted fee program (nominal/sliding fee discount) to eligible patients who apply for assistance. The discounts are based on the Federal Poverty Guidelines. Discounts are given up to 200% of the Federal Poverty Level. Income verification must be provided **before discounts will be applied**. Discounts will not be given to households above 200% of the Federal Poverty Level.

Is Patient head of Household? [ ] yes [ ] no

If no, who is the head of Household? \_\_\_\_\_

List all dependents (anyone who resides with you and for whom you have legal, custodial, or financial responsibility). Please list the **total monthly** gross income for each household member.

<i>Name</i>	<i>Relation to Patient</i>	<i>Birth Date</i>	<i>Income</i>
	<i>self</i>		

By signing this application, I represent that the information and answers given in this application are true, complete and correctly recorded. If fraudulent misstatements were made, the organization reserves the right to request full payment for services provided to the patient. I understand that any charges for my household that are not covered by the discounted service program are my responsibility for my household and I agree to pay for these charges

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## *For office use only:* Show your calculations

Total Annual Income: \_\_\_\_\_ Total of Household Members Qualified: \_\_\_\_\_

Eligible for Sliding Fee Discount Program Level: (Circle one)

**MEDICAL:** [A -\$30] [B - 20%] [C - 40%] [D - 60%] [E - 80%] [F- 95%] [G - 100%]

**DENTAL:** [A -\$60] [B -40%] [C -30%] [D -20%] [E - 10%] [F- 5%] [ G- 100%]

EFFECTIVE DATE: \_\_\_\_\_ EXPIRATION DATE: \_\_\_\_\_

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_



# CONSENT TO TREATMENT

I give permission for ARcare/KentuckyCare/MississippiCare to give \_\_\_\_\_  
medical treatment. Patient's Name

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

*Initial ONE:*

- I am the patient.
- Patient is a minor who is \_\_\_\_\_ years of age.
- Patient is an adult who cannot act on his or her own.

*If Patient is a minor:*

I give permission for my child to receive an examination and treatment in the absence of adult supervision.

- Yes  No

I give permission for the following individuals (other than parent/legal guardian) to bring my child to the clinic on my behalf (**Select at least ONE**):

- None  School staff  Clinic staff  Daycare staff  Other (*please list*)

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Emergency Contact	Relationship	Phone Number

1. I voluntarily consent to medical care recommended by the medical provider including, x-rays, heart tracings, medications, and/or routine laboratory testing (including human immunodeficiency virus infection, hepatitis, or any other blood-borne infectious disease if ordered by a clinician for diagnostic purposes).
2. I authorize the clinic to release medical information to insurance carriers for the purposes of filing insurance claims related to my/his/her medical care.
3. I agree that insurance (if applicable) will billed for services and I (patient, parent or guardian of the patient) am responsible for any charges not paid or denied by the insurance company.
4. I understand that even if you have a copy of my Advance Directive or Living Will that clinic staff will attempt to stabilize me and transfer me to an acute care hospital for further evaluation and treatment.
5. This form has been fully explained to me and I understand its contents.

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of patient or adult consenting for patient      Relationship to Patient      Date

\_\_\_\_\_  
Signature of staff who explained the contents of this consent form      Date



## Consent to Obtain Medication History

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your “medication history.” A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.

The medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history.

**I give permission for you to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.**

Patient's Name:

Signature:

Date:



## HIPAA PRIVACY PRACTICES CONSENT FORM

We are committed to providing security for patient privacy and confidentiality. We collect, use, and disclose personal health information only when allowed by state and federal laws and your personal authorization. This may include the collection of other sources of information available, such as medication and prescription history and verification of insurance eligibility.

We also understand you may have family members or significant people in your life who you may want to have access to certain information contained in your medical record. Without your written consent, we cannot release any information to anyone except for purposes outlined in the HIPAA privacy act. **Please note that we use an automated phone system to remind you of appointments as well as offer patients the opportunity to complete a survey about their visit.**

I give permission for those (employees, students, volunteers, contractors, etc.) acting on behalf of the organization to share my protected health information (PHI) with the following specific person(s): ***(If no other person is authorized to receive your PHI, write N/A in the spaces below.)***

<i>Name of Individual to which information can be released</i>	<i>Information to be released (Enter corresponding # from list)</i>

**Information to be released:**

- [1] Copy of complete health record
- [2] History and physical
- [3] Test results
- [4] Mental health records
- [5] Reproductive health records
- [6] Other

***If 12-17 years of age, patient must sign here to acknowledge approval of information to be released.***

***\*\*I understand that I can revoke this release of medical information at any time by completing a new form.***

I give my permission to: ***(INITIAL all that apply) MUST INITIAL AT LEAST ONE***

- [  ] Leave a message on my answering machine or other electronic device(s) about my appointments, lab results, follow-up care, or other medical information
- [  ] Contact me at my home address and phone number.
- [  ] Leave a message with the person indicated as a “message” number if I cannot be reached otherwise.
- [  ] Send me an email message at: \_\_\_\_\_.
- [  ] Contact me regarding voluntary participation in a clinical research. I understand that by checking this box I am NOT obligated to participate in any specific project. Please contact me about projects by:  
 mail       phone       email address:
- [  ] I have received a copy of the Notice of Privacy Practices.

\_\_\_\_\_  
Print Name of PATIENT

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Patient OR Guardian

\_\_\_\_\_  
Date



## PATIENT FINANCIAL OBLIGATION FORM

I UNDERSTAND THE FOLLOWING:

- I am responsible for any charges that are incurred during my office visit.
- If I have insurance, I am responsible for co-pays, deductibles and co-insurance.
- If I fail to meet my financial obligations, my account will be sent to a collection agency after 90 days.
- I will have an opportunity to pay on this account before it will be sent to collections.
- I will receive 3 statements before my account will be turned over to collections.
- If I overpay and have a credit, the credit will be applied to other open claim balances. If no open claim balance exists and I have been turned over to a collection agency in the past, an in-house credit will be provided and issuance of a refund check will be deferred for one year.
- A payment plan is available at my request for unpaid balances before going to collections.
- Should I be unable to make a payment on my account at this time, I understand that the clinic will see me regardless of my ability to pay.

**The organization's discounted fee program has been explained to me.**

**I do [ ] OR do not [ ] wish to participate in this program.**

### DISCLAIMER

I understand, acknowledge, and agree that to collect any money that I owe to the facility:

- I may be contacted by telephone or text message to any phone number that I give or is included on my account (including cell phone numbers that can result in charges on my phone account).
- ARcare/KentuckyCare/MississippiCare, or any other collection or servicing agency operating on behalf of the organization may contact me with auto dialing devices, pre-recorded messages, or voice mail messages.
- ARcare/KentuckyCare/MississippiCare, or any other collection or servicing agency operating on behalf of the organization may contact me using any e-mail address I provide to the organization or that is included on my account.

I understand the collection policy as explained above.

\_\_\_\_\_  
Patient OR Guarantor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date of Birth

Patient OR Guarantor Mailing Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Staff Witness Signature

\_\_\_\_\_  
Date



## NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the  
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY

### A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information as protected by law, including the Health Information Portability and Accountability Act (HIPAA). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your Personally Identifiable Information (PII). By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PII
- Your privacy rights in your PII
- Our obligations concerning the use and disclosure of your PII

This notice describes ARcare's/KentuckyCare's/MississippiCare's privacy practices and that of:

- All of our doctors, nurses, and other health care professionals authorized to enter information about you into medical chart.
- All of our departments including medical records, billing and insurance departments.
- All of our employees, staff, volunteers and other personnel who work for us or on our behalf.
- In addition these sites and locations may share medical information with each other for treatment, payment or operation purposes described in this notice.

**The terms of this notice apply to all records containing your PII that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and doe any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.**

### B. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE:

**Privacy Officer  
P.O. Box 497, Augusta, AR 72006  
Phone: (870)347-3474**

### C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PII) IN THE FOLLOWING WAYS:

1. **Treatment.** Our practice may use your PII to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PII in order to write a prescription for you, or we might disclose your PII to a pharmacy when we order a prescription for you. Many of the people who work for our practice- including, but not limited to, our doctors and nurses- may use or disclose your PII in order to treat you or to assist others in your treatment. Additionally, we may disclose your PII to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PII to other health care provides for purpose related to your treatment.

2. **Payment.** Our practice may use and disclose your PII in order to bill and collect payments for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits) and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PII to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PII to bill you directly for services and items. We may disclose your PII to other health care providers and entities to assist in their billing and collection efforts. You have the right to restrict disclosures of protected health information to health plans if you have paid for services out of pocket in full.
3. **Health Care Operations.** Our practice may use and disclose your PII to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PII to evaluate the quality of care you received from us, or to conduct cost- management and business planning activities for our practice. We may disclose your PII to other health care providers and entities to assist in their health care operations. We may make your health information available electronically through an electronic health information exchange to other health care providers and healthcare plans that request your information for their treatment and payment purposes. Participation in electronic health information exchange also lets us see their information about you for our treatment and payment purposes.
4. **Appointment Reminders.** Our practice may use and disclose your PII to contact you and remind you of an appointment.
5. **Treatment Options.** Our practice may use and disclose your PII to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your PII to inform you of health-related benefits or services that may be of interest to you.
7. **Fundraising.** We may contact you to raise funds for our organization.
8. **Release of Information to Family/ Friends.** Our practice may release your PII to a friend or family member that is involved in your care or assists in taking care of you. For example, a parent or guardian may ask a babysitter to take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.
9. **Disclose Required by Law.** Our practice will use and disclose your PII when we are required to do so by federal, state, or local law.

#### **D. USE AND DISCLOSURE OF YOUR PII IN CERTAIN SPECIAL CIRCUMSTANCES**

The following categories describe unique scenarios in which we may use or disclose your personally identifiable health information.

1. **Public Health Risks.** Our practice may disclose your PII to public health authorities that are authorized by law to collect information for the purpose of:
  - Maintaining vital records, such as births and deaths
  - Reporting child abuse or neglect
  - Preventing or controlling disease, injury or disability
  - Notifying a person regarding potential exposure to a communicable disease
  - Notifying a person about a potential risk for spreading or contracting a disease or condition
  - Reporting reactions to drugs or problems with products or devices
  - Notifying individuals if a product or device they may be using has been recalled
  - Notifying appropriate government agencies and authorities regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
  - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
2. **Health Oversight Activities.** Our practice may disclose your PII to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your PII in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PII in response to a discover request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party had requested.
4. **Law Enforcement.** We may release PII if asked to do so by law enforcement official:

- Regarding a crime victim in certain situation, id we are unable to obtain the person’s agreement
  - Concerning a death we believe had resulted from criminal conduct
  - Regarding criminal conduct at our offices
  - In response to a warrant, summons, court order, subpoena or similar legal process
  - To identify/locate a suspect, material witness, fugitive or missing person
  - In an emergency, to report a crime (including the location or victim (s) of the crime, or the description, identity or location of the perpetrator)
5. **Deceased Patients.** Our practice may release PII to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their job.
  6. **Organ and Tissue Donation.** Our practice may release your PII to organizations or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order or tissue donation and transplantation if you are an organ donor.
  7. **Research.** Our practice may use and disclose your PII for research purpose in certain limited circumstances. We will obtain your written authorization to use your PII for research purpose except when Internal or Review Board of Privacy Board has determined that the wavier of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and discloser; (B) and adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurance that the PII will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the reach study, or for other research for which the use of discloser would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PII.
  8. **Serious Threats to Health or Safety.** Our practice may use and disclose your PII when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
  9. **Military.** Our practice may disclose your PII if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
  10. **National Security.** Our practice may disclose your PII to federal officials for intelligence and national security activities authorized by law. We also may disclose your PII to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations..
  11. **Workers’ Compensation.** Our practice may release your PII for workers’ compensation and similar programs.
  12. **Coroner, Medical Examiner, Funeral Director.** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.
  13. **Business Associates.** We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
  14. **Inmates or Individuals in Custody..** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (a) for the institution to provide you with health care; (b) to protect your health and safety or the health and safety of others; or (c) the safety and security of the correctional institution.

## **E. YOUR RIGHTS REGARDING YOUR PII**

You have the following rights regarding the PII that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work, in order to request a type of confidential communication, you must make a written request to the Privacy Officer specifying the requested method of contact or the location where you wish to be contacted, our practice will accommodate reasonable request. You do no need to give a reason for your request.
2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your PII for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PII to other certain individuals involved in your care or the payment for your care, such as family members and friends. **We are**



**not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PII, you must make your request in writing to the Privacy Officer. Your request must describe in a clear and concise fashion:

- a) the information you wish restricted;
  - b) whether you are requesting to limit our practice's use, disclosure or both; and
  - c) to whom you want the limits to apply
- 3. Inspection and copies.** You have the right to inspect and obtain a copy (paper or electronic) of the PII that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the privacy Officer in order to inspect and/or obtain a copy of your PII. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
- 4. Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion (a) accurate and complete; (b) not part of the PII kept by or for the practice; (c) not part of the PII which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
- 5. Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain not-routine disclosures our practice has made of your PII for non-treatment, not payment or non-operations purpose. Use of your PII as part of the routine patient care in our practice is not required to be documented. For example, the doctor was sharing information with nurse; or the billing department using your information to file your insurance claim. Also, we are not required to document disclosures made pursuant to an authorization signed by you. To obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer. All requests for an accounting of disclosure must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month periods is free of charge; but our practice may charge you for additional lists within the same 12-month periods. Our practice will notify you of the costs involved with addition requests, and you may withdraw your request before you incur any costs.
- 6. Rights to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the Privacy Officer.
- 7. Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Privacy Officer.

**Privacy Officer**  
**P.O. Box 497, Augusta, AR 72006**  
**Phone: (870)347-3474**

We urge you to file your complaint with us first and give us the opportunity to address your concerns. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

- 8. Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses/disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PII may be revoked at any time in writing. After you revoke you authorization, we will no longer use or disclose your PII for the reasons described in the authorization. Please note, we are required to retain records of you care.
- 9. Right to Notice in the Event of a Breach.** Our practice will notify you in the event there is a breach of your PII.

*For complete details about how we may use your PII, please visit:*

<https://www.arcare.net/PrivacyPolicy>  
<https://www.kentuckycare.net/PrivacyPolicy>  
<https://www.mississippicare.net/PrivacyPolicy>



## ARcare/KentuckyCare/MississippiCare

This organization is a private non-profit corporation developed in 1986 to meet the primary care needs of residents in its service area. This includes providing education and prevention programs to supplement services available through other area agencies as well as providing quality service to all residents. This organization has been accredited by the Joint Commission since 1997 and is recognized as Primary Care Medical Homes committed to improving primary care and improving the quality, safety, efficiency, and effectiveness of health care through these approaches:

- **Patient-centered:** A partnership among practitioners, patients, and their families ensures that decisions respect patients' wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care.
- **Comprehensive:** A team of care providers is wholly accountable for a patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care.
- **Coordinated:** Care is organized across the health care system, including specialty care, hospitals, home health care, community services and supports. This supplies comprehensive health information to those that are providing your care and helps to determine the best place for you to access care that you need.
- **Accessible:** Patients are able to access services with expanded after-hours care, 24/7 electronic or telephone access, and through your personal patient portal. You also have access to patient education materials through your patient portal, our websites, and through our patient education programs.
- **Committed to quality and safety:** Your health care team is focused on quality care and ensure that patients and families can make informed decisions about their health. We also follow evidence-based care guidelines so that we can help you maximize your health.

Services are available in multiple clinic sites located throughout Arkansas, Kentucky, and Mississippi. Primary Health Care services provided include primary care, emergency medical care, and wellness services. Specialty services offered in limited areas include: diagnostic lab and x-ray, pharmacy, transportation, behavioral health, substance abuse treatment, and HIV/AIDS services. We also offer Diabetic Education Centers, Wellness Centers, Aging Illness Management, and Cancer Care as special programs in some areas.

All clinics are open Monday-Friday 8 a.m. to 5 p.m. with some evening and weekend hours. If you need medical services after regular business hours, please call:

ARcare: **501-268-6121**

KentuckyCare: **877-791-9154**

MississippiCare: **501-530-6016**

For over thirty years, individuals and families have trusted this organization for quality care, regardless of ability to pay. Our patients include those with insurance, those without insurance, and those lacking enough insurance. Private insurance and Medicare are accepted. This center participates in the Medicaid Managed Care Program and provides eligibility assistance for other Medicaid programs. Although we are not a free clinic, we offer discounted (nominal) fees to eligible patients so that everyone can receive the care they need.

For questions or more information about services, locations, or patient health education services please contact:

**877-578-9400** or visit our websites at: <https://www.arcare.net> <https://www.kentuckycare.net>

<https://www.mississippicare.net>

## **Clinic Locations & Phone Numbers**

### **ARKANSAS**

Augusta Longevity & Cancer Center: 870-347-3451

Augusta Pediatric Clinic: 870-347-3402

Batesville-Vine Medical: 870-793-4600

Benton Medical: 501-860-7150

Brinkley Medical: 870-734-1150

Cabot South Medical: 501-941-0940

Cabot West Medical: 501-941-1376

Cherry Valley Medical: 870-442-2040

Conway Medical: 501-932-9010

Des Arc Medical: 870-256-4178

Hazen Medical: 870-255-3696

Horseshoe Bend Medical: 870-670-4861

Jonesboro Midtown Medical: 870-333-5476

Jonesboro South Medical: 870-336-1675

Lake City Medical: 870-237-9928

Lonoke Medical: 501-676-0181

McCrary Medical: 870-731-5411

Melbourne Medical: 870-368-5030

Parkin Medical: 870-755-2234

Searcy Medical: 501-279-7979

Southside Medical: 870-569-4934

Vilonia Medical: 501-796-6740

Augusta Medical Clinic: 870-347-2508

Augusta Pharmacy: 870-347-5150

Bald Knob Clinic: 501-724-6207

Batesville-Harrison Medical: 870-307-0001

Brinkley Pharmacy: 870-734-1100

Cabot East Medical: 501-941-3522

Cabot Pharmacy: 501-941-3116

Carlisle Medical: 870-552-7303

Cotton Plant Medical: 870-459-3588

England Medical: 501-842-3131

Heber Springs Medical: 501-362-9426

Jacksonville Medical: 501-241-1676

Jonesboro North Medical: 870-802-3586

Kensett Medical: 501-742-5697

Little Rock Primary Care: 501-455-2712

Mayflower Medical: 501-470-9780

McCrary Medical 2: 870-347-1100

Newport Medical: 870-523-2944

Parkin Pharmacy: 870-755-2838

Searcy Medical 2: 501-203-0857

Swifton Medical: 870-485-2234

Wynne Clinic: 870-238-0377

### **KENTUCKY**

Bardwell Medical: 270-628-3333

Mayfield Medical: 270-804-7710

Paducah South Medical: 270-443-9474

Murry Medical: 270-753-2395

Barlow Medical: 270-334-3131

Paducah Medical: 270-575-3247

Paducah Pharmacy: 270-408-1584

### **MISSISSIPPI**

Pontotoc Medical: 662-490-1985



Welcome to *your Medical Home*.

Patient-centered is a way of saying that you, the patient, are the most important person in the health care system.

*You* are the center of your health care.

A Medical Home is an approach to providing total health care. With your Medical Home, you will have a personal clinician and a care team that includes other health care professionals, trusted friends, or family members (if you wish), and – most importantly—YOU!

### **You and Your Medical Home team will work together:**

- Your personal clinician and medical home team will get to know you and your family. They can help you manage your total health care. You can see the same team each time you visit, and they can help answer your health questions.
- The medical home team will listen to your questions and help you find your way through the sometimes confusing health care system.
- If you need to get help from other doctors, your team can support you every step of the way. For example, if you need to see a specialist, your team can keep in touch with the specialist to make sure you get the care you need.
- Your medical home will have convenient office hours to help you get an appointment at a time that works for you. You can also access your personal health portal to view your medical information and contact your health care team.

### **Together, you and your team can work out a plan just for you, including:**

- Personalized health care that meets your needs
- Tracking of your care so that you have all of your health care records in one place
- More ways to keep in touch with your health care team

### **Get the most out of your Medical Home:**

- Bring your list of questions, concerns, and medications
- Ask questions and share in the decision making process
- Follow your care plan and keep your health care team informed

*For more information about your Medical Home, contact your clinic or visit*  
[www.arcare.net](http://www.arcare.net) [www.kentuckycare.net](http://www.kentuckycare.net) [www.mississippicare.net](http://www.mississippicare.net)



## Visit Checklist

**A Medical Home is an approach to providing total health care. With your Medical Home, you will join a team that includes health care professionals, trusted friends, or family members (if you wish).**

<b>Get Ready For Your Appointment</b> (Use this handy <b>checklist</b> )	<b>During Your Appointment</b> (Use this handy <b>checklist</b> )
<ul style="list-style-type: none"><li>○ Make a list of your health questions. Ask a friend or relative for help if you need it. Put the questions that are most important to you at the top of the list.</li></ul>	<ul style="list-style-type: none"><li>○ Write down the names of your team members:</li></ul>
<ul style="list-style-type: none"><li>○ Make a list of other health care providers you have visited. Write down their names, addresses, phone numbers, and the reasons you visited them.</li></ul>	<ul style="list-style-type: none"><li>○ Use your list of questions. Ask your most important questions first. Even if you cannot get all of your answers on the first visit, having a list will help you keep track of the answers.</li></ul>
<ul style="list-style-type: none"><li>○ Take all of your medicines in their original containers to your appointment. Be sure to include all medications including prescriptions, over-the-counter, natural and herbal medications as well as vitamins.</li></ul>	<ul style="list-style-type: none"><li>○ Talk with your health care team about what health issue to work on first.</li></ul>
<ul style="list-style-type: none"><li>○ If you have insurance, take your insurance card or other insurance information with you to the appointment.</li></ul>	<ul style="list-style-type: none"><li>○ Be sure you know what you should do before you leave the office.</li></ul>
<ul style="list-style-type: none"><li>○ If you wish, ask a family member or trusted friend to go to your appointment with you.</li></ul>	<ul style="list-style-type: none"><li>○ Use your own words to repeat back the things you have discussed with your health care team. This way both you and your team will know the information is understood.</li></ul>