UAMS

ANGELS – New Patient Packet

Antenatal & Neonatal Guidelines, Education & Learning System
Telemedicine Clinic
1.866.273.3835 (toll free)

Your telemedicine appointment has been scheduled. Please arrive 30 minutes early for your appointment. The information below should help you know what to expect at your visit. Please understand that the equipment shuts down automatically, so it is VERY important that you arrive on time with your completed paperwork. If you are 15 minutes late, you will need to reschedule. Please call our toll free number 1.866.273.3835.

Please remember to **bring all forms mailed to you** including the Consent Forms, Genetics Information and Acknowledge of Receipt of Privacy Notice. These forms should be completed BEFORE you arrive for your appointment. Your completed paperwork is essential. It is needed for an accurate, updated medical record.

You may not be seen if your forms are not completed and presented.

Bring Blood Sugar Logs to Clinic Every Visit.

What to Expect: Your telemedicine appointment will be a lot like other doctor appointments you have experienced. When you arrive at the clinic, you will need to give your completed forms to the person at the registration desk. They will fax the information to the health care providers at UAMS so it can be reviewed during your visit. Your completed paperwork is extra important. It helps the health care team get a better understanding of your situation.

Just like usual doctor appointments, you will go into a patient room. If you prefer, family members may be invited into the room with you. The door to the room will be closed for privacy. A physician, nurse and/or ultra-sonographer will also be in the room. You will receive the same kind of exams that you would receive during a usual appointment.

You will see a piece of equipment that may look like a TV or it may have two screens and a small camera. Using the equipment, you will be introduced to the health care professionals at UAMS. You will be able to see and hear them, and they will be able to see and hear you. You may move and talk naturally. If you have an ultrasound, you, the health care providers at your local clinic and the professionals at UAMS will be able to look at it. The health care providers at your local clinic and UAMS will discuss your situation. You will be part of the discussion, so the UAMS providers may ask you questions. Do not hesitate to ask any questions.

The basic difference with a telemedicine appointment is that you will be talking with a physician or health care professional who is not in the same room with you. Though they are actually at UAMS, the telecommunication equipment allows you to see, hear and communicate with the health care providers at UAMS almost like they were standing next to you.

Keeping this appointment is very important. We hope that telemedicine will save you some travel time and inconvenience. Your input is valuable and helps us improve access and quality of health care. **When your session is finished, please fill out the *Telemedicine Patient Post-Session Evaluation Form* in your packet**. If you have any questions, please feel free to call us toll free at 1.866.273.3835.

UAMS

APPENDIX A

ANGELS Telemedicine

What is ANGELS?

The ANGELS program intends to improve neonatal outcomes. ANGELS does this with evidence-based care guidelines, research, health care education and a 24/7 call center. Using telemedicine technology, ANGELS also offers consultations by UAMS board certified maternal fetal medicine physicians. The only service of its kind in the nation, ANGELS is a joint program of University of Arkansas for Medical Sciences (UAMS) College of Medicine, the Arkansas Department of Human Services and the Arkansas Medical Society. This unique program is designed to be a support network for high-risk obstetric patients and practitioners in Arkansas. To learn more about ANGELS, visit http://www.uams.edu/angels.

What is telemedicine?

Telemedicine is the delivery of medical care or services from a distant site. Telemedicine utilizes interactive video and audio teleconferencing technology that allows a physician at UAMS to see the patient and/or sonogram in real time (almost at the same speed as in person). When needed, ANGELS utilizes specialized ultrasound equipment that digitally transfers a sonogram image to UAMS.

What are the benefits and limits of ANGELS telemedicine?

UAMS is the only facility in the state to have a team of board certified maternal fetal medicine specialists and genetic counselors to provide comprehensive care for high-risk obstetric patients. ANGELS brings this consultative expertise to patients and community-based physicians across the state, saving transportation cost and time. In addition, community-based physicians receive valued support to their primary care delivery. However, telemedicine does have limits. Some conditions are best assessed in the clinic in Little Rock.

What about consent and privacy?

ANGELS is dedicated to protecting patient rights and privacy. You will be asked to sign a consent giving your permission to be seen via telemedicine. When you sign this consent, you are agreeing to the electronic transfer of your images and Protected Health Information (PHI) as well as the limits outlined. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the establishment of standards to protect patient privacy and confidentiality. ANGELS equipment encrypts data for security; however, telemedicine equipment is new technology, and there is a very small possibility that the data could be intercepted by unauthorized persons.

How does a clinic visit work?

Basically, ANGELS connects to your location via secure cable lines that allow the equipment to "talk to each other." You will present to the outpatient visit just as you would for any other clinic visit. In addition to the consulting specialists and nurse, you may be seen by a genetic counselor. You will see and hear each other in real time. The only difference is that you will see each other and the ultrasound on a television-like LCD screen.

UAMS

What conditions may be seen over telemedicine?

Many different conditions can be seen over telemedicine. Some of the conditions that we can detect include advanced maternal age, maternal exposures, maternal diseases, elevated maternal serum screen, family history of chromosomal abnormalities, suspected fetal anomalies detected during a level I ultrasound, oligohydramnios, polyhydramnios, fetal arrhythmias, and intrauterine abnormalities. Face-to-face consults are also accommodated.

What about reimbursement?

Call ANGELS for any needed help with billing issues at 1.866.273.3835 (toll free).

What about telemedicine physicians?

The telemedicine physicians at UAMS are consultants for you and your primary physician. This means that your primary physician will not change. In addition, this means that information and outcomes of your telemedicine clinic appointment will be communicated to your primary physician.

What if I have questions?

PLEASE ASK ANY QUESTIONS YOU MAY HAVE. There are no dumb questions. Out staff welcomes questions. You may ask the telemedicine nurse, genetic counselor or physician questions at any time during your clinic visit. If you need information about appointments, insurance, your rights or anything else, please call the ANGELS Call Center at 1.866.273.3835 (toll free).

022817 kkm
022817 rperkins

UAMS Medical Center
Arkansas Reproductive Genetics Program
4301 West Markham #506
Little Rock, Arkansas 72205
(501) 296-1700

UAMS

Dear

We are requesting that you fill out the attached Authorization for Release of Information form. Please complete items 1-4 and sign and date item number 9. This information is very important to us. We use this information for quality assurance and for compiling statistical information as well as applying for financial grants to develop studies to help future expectant mothers.

Please be assured that your information and that of your baby will only be used and disclosed in accordance with the HIPPA Privacy Rules and UAMS Privacy Policies. If you have any questions, your counselors will be glad to answer them for you.

Thank you for your cooperation and assistance!

Dr. Curtis L. Lowery

Director UAMS Prenatal Diagnosis Program Arkansas
Reproductive Genetics Program

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Address:

UAMS
Medical Center

Authorization for Release of Information TO UAMS

Arkansas Reproductive Genetics Program

I hereby authorize the Hospital where I deliver my baby and my Obstetrician to release medical information on the **patient (mother) and baby** of patient to:

UAMS Medical Center, Arkansas Reproductive Genetics Program, 4301 West Markham, Mail Slot 506, AR 72205, Phone (501) 296-1700, Fax (501) 296-1701.

1. **Estimated date of delivery:** _____
2. **Name of Hospital** where _____
   I plan to deliver my baby **(if known)**
   Address _____
   Street Address *City* *State* *Zip*
3. **Name of My Obstetrician:** _____
4. **Name of patient/mother** _____
   Medical Record # of mother (if known)_____ of baby (if known) _____
   Mother's Date of Birth +/or Social Security #: _____
   Phone #: _____
5. Information requested to be released
   - _X_ Delivery room report
   - _X_ Operative Report
   - _X_ Discharge-Summary
   - ___ Baby's History & Physical
   - ___ Other _____
   - _X_ Baby's Admission Record
   - _X_ Baby's Discharge Summary
   - _X_ Autopsy report
6. Purpose of release is at the request of the patient or: ____ Insurance or Other Payment
   ____ Medical Care ____ Other (explain): _____
7. This Authorization will expire 18 months from the date I signed this Authorization. I understand that I am not required to sign this Authorization, and that I may revoke this Authorization at any time by giving written notice to the Hospital where my baby is delivered. A revocation of this Authorization will not apply to records already released in reliance upon the Authorization. A photocopy of this signed Authorization shall constitute a valid Authorization.
8. I understand that once the above information is disclosed, it may be re-disclosed by the party receiving the information, and the information may no longer be protected by Federal privacy laws and regulations. However, information disclosed to UAMS is protected by Federal privacy laws and regulations.
9. Treatment, payment, and enrollment or eligibility for benefits will not be conditioned on your signing this Authorization.

Signature of Patient/ Legal Representative _____ **Date/Time:** _____

If Legal Representative signs for Patient (mother), state relationship: _____ **Date:** _____
(such as parent of a minor, court-appointed guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or health care proxy)

NOTE TO STAFF: Provide Copy of Signed Authorization to Patient/Legal Representative

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Address:

UAMS
Medical Center

Acknowledgment of Receipt of Privacy Notice

By signing this form, you are only agreeing that you have received a copy of the UAMS Notice of Privacy Practices.

Patient Signature _____ Date _____ Time _____

Print Legal Representative's Name (if applicable) _____ Legal Representative's Signature _____

If Legal Representative, authority of Legal Representative _____
(such as parent of a minor, guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or healthcare proxy)

STAFF USE ONLY

We provided the Notice of Privacy Practices and attempted to obtain written acknowledgment but acknowledgment could not be obtained because:

☐ Patient or Legal Representative declined to sign the Acknowledgment of Receipt.

☐ Other (please specify) _____

Printed Name of Employee Completing Form _____ Date _____ Time _____

Signature of Employee Completing Form _____ UAMS Location _____

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Address:

UAMS
Medical Center

NOTICE OF PRIVACY PRACTICES

Effective Date: April 8, 2013

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.

This Notice is provided on behalf of the University of Arkansas for Medical Sciences including its Medical Center Research Institute, and clinics, Psychiatric Research Institute, Area Health Education Centers, and other facilities ("UAMS"). UAMS provides patient care through a healthcare system committed to education and research.

PURPOSE: This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out treatment, payment or healthcare operations and for other purposes permitted or required by law. "Protected Health Information" is information that may identify the patient and that relates to the patient's past, present or future physical or mental health, and may include name, address, phone numbers and other identifying information.

We are required to give you this Notice and to maintain the privacy of your Protected Health Information. We must abide by this Notice, but we reserve the right to change the privacy practices described in it. A current version of this Notice, with required revisions, if any, may be obtained from the UAMS web site, http://www.uamshealth.com/ and will be posted in prominent areas of our facilities. You may also receive a current copy by sending a written request to the UAMS HIPAA Office, 4301 W. Markham #829, Little Rock, AR 72205.

We understand that medical information about you and your health is personal and confidential, and we are committed to protecting the confidentiality of your medical information. We create a record of the care and services you receive at UAMS Medical Center and its clinics, Area Health Education Centers and other UAMS facilities. We need this record to provide services to you and to comply with certain legal requirements. This Notice will tell you about the ways we may use and disclose your information. We also describe your rights and certain obligations we have to use and disclose your health information.

If you believe your Privacy Rights have been violated, you may complain to us or to the U.S. Secretary of Health and Human Services. To file a complaint with us, you may send a letter describing the violation to the UAMS HIPAA Officer, 4301 W. Markham #829, Little Rock, AR 72205. There will be no retaliation for filing a complaint.

If you have questions or need more information, contact the UAMS HIPAA Office at 501-614-2187.

WHO WILL FOLLOW THIS NOTICE: This Notice describes the practices of UAMS healthcare professionals, employees, volunteers and others who work or provide healthcare services at any UAMS facility, including students-in-training.

ACKNOWLEDGMENT: You will be asked to sign an Acknowledgment of receipt of this Notice. The delivery of your healthcare services will in no way be conditioned upon the signing of this Acknowledgment.

Your Privacy Rights. You have the following rights relating to your Protected Health Information. You may:

- Obtain a current paper copy of this Notice.
- Inspect or obtain a copy of your records, in paper or electronic form. You may be charged a fee for the cost of copying, mailing or other supplies. We are allowed to deny this request under certain circumstances. In some situations, you have the right to have the denial of your request reviewed by a licensed healthcare professional identified by UAMS who was not involved in the original denial decision. We will comply with the outcome of this review.
- Request that we amend your record, if you feel the information is incomplete or incorrect. We are allowed to deny this request in certain circumstances and may ask you to put these requests in writing and provide a reason that supports your request.
- Request in writing a restriction on certain uses and disclosures of your information. We are not required to agree to the requested restrictions, unless you are requesting to restrict certain information from your health plan and have paid for your UAMS services in full.
- Obtain a record of certain disclosures of your Protected Health Information.
- Make a reasonable request to have confidential communications of your Protected Health Information sent to you by alternative means or at alternative locations.
- Provide us with written permission for uses and disclosures of your Protected Health Information that are not covered by the Notice or permitted by law. Except to the extent that the use or disclosure has already occurred, you may cancel this permission. This request to cancel must be put in writing.
- Submit any written requests to inspect, copy or amend your records to the UAMS Health Information Management Department.

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Address:

UAMS
Medical Center

NOTICE OF PRIVACY PRACTICES

Our Responsibilities. We are required to protect the privacy of your Protected Health Information, abide by the terms of the Notice, and make the Notice available to you. We are also required to notify you if a breach of your health information occurs.

Examples of Uses & Disclosures

We will use your Protected Health Information for treatment. Certain information obtained by a nurse, doctor, therapist, or other healthcare worker will be put into your record and used to plan and manage your treatment. We may provide reports or other information to your doctor or other authorized persons who are involved in your care, including healthcare providers outside of UAMS. We may make your protected health information available electronically through an electronic health information exchange to other health care providers and health care providers and health plans that request your information for their treatment and payment purposes. Participating in an electronic health information exchange may also let us see their information about you for our treatment and payment purposes.

We will use your Protected Health Information for payment. A bill will be sent to you and/or your insurance company with information about your diagnosis, procedures and supplies used. We may also disclose limited information about your bill to others, such as collection agency, to obtain payment.

We will use your Protected Health Information for regular healthcare operations. UAMS may use your Protected Health Information to check on the care you received, how you responded to it, and for other business purposes related to operating the hospital or clinics. UAMS is a teaching facility, and information about you may be shared with students and trainees for teaching purposes.

Business Associates: We may share some of your Protected Health Information with outside people or companies who provide services for us, such as typing physician reports.

Patient Directory: Unless you tell us not to, we may disclose your name, location in the facility, and general condition to people who ask for you by name. If provided by you, your religious affiliation may also be given to members of the clergy.

Notification: We may use or disclose your Protected Health Information with a family member or other person involved in your care, your location and general condition unless you tell us not to do so.

Communication with family: We may share your Protected Health Information with a family member, a close personal friend, or a person that you identify, if we determine they are involved in your care or in payment for your care, unless you tell us not to do so.

Research: Your Protected Health Information may be used for research purposes in certain circumstances with your permission, or after we receive approval from a special review board whose members review and approve the research project.

Coronors, Medical Examiners, Funeral Directors: In the event of your death, we may disclose your Protected Health Information to these people, to the extent allowed by law, so that they may carry out thier duties.

Organ Donor Organizations: We may share your Protected Health Information with the organ donation agency for the purpose of tissue or organ donation in certain circumstances and as required by law.

Contacts: We may contact you to provide appointment reminders or to tell you about new treatments or services.

Fundraising and Marketing: We may contact you as part of UAMS fundraising or marketing efforts. You have a right to opt out of Fundraising communications and may do so by calling 1-888-995-UAMS (8267) or emailing advancement@uams.edu.

Food and Drug Administration: We may share your Protected Health Information with certain government agencies like the FDA so they can recall drugs or equipment.

Workers Compensation: We may disclose your Protected Health Information for workers' compensation claims.

Public Health: We may give your Protected Health Information to public health agencies who are charged with preventing or controlling disease, injury or disability and as required by law.

Communicable Disease: We may disclose your Protected Health Information to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition, if authorized by law to do so, such as a disease requiring isolation.

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Address:

UAMS
Medical Center

NOTICE OF PRIVACY PRACTICES

Correctional Institution: If you are an inmate of a correctional institution, we may disclose your Protected Health Information to the institution or law enforcement as needed for your health or the health and safety of others.

Law Enforcement: We must disclose your Protected Health Information for law enforcement purposes as required by law.

As Required by Law: We must disclose your Protected Health Information when required by federal, state or local law, such as to report gunshot wounds.

Health Oversight: We must disclose your Protected Health Information to a health oversight agency for activities authorized by law, such as investigations and inspections. Oversight agencies are those that oversee the healthcare system, government benefit programs, such as Medicaid, and other government regulatory programs.

Abuse or Neglect: We must disclose your Protected Health Information to government authorities that are authorized by law to receive reports of suspected abuse or neglect involving children or endangered adults.

Legal Proceedings: We must disclose your Protected Health Information in the course of any judicial or administrative proceeding or in response to a court order, subpoena, discovery request or other lawful process, as allowed by law.

Required Uses and Disclosures: We must make disclosures when required by Secretary of Department of Health and Human Services to investigate or determine our compliance with the HIPAA Privacy Regulations.

To Avoid Harm: We may use and disclose information about you when necessary to prevent a serious threat to your health or safety of the health or safety of the public or another person.

For Specific Government Functions: In certain situations, we may disclose Protected Health Information of military personnel and veterans. We may disclose your Protected Health Information for national security activites required by law.

Sale of Information: UAMS will not sell your information without your prior written authorization or as otherwise allowed by law.

UAMS

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Address:

ANGELS
Antenatal & Neonatal Guidelines, Education & Learning System
Telemedicine Clinic
1.866.273.3835 (toll free)

INSURANCE

It is your responsibility to work with your physician and insurance carrier to meet the requirements of your policy. Failure to do so may result in a denial/reduction of insurance coverage. If your insurance carrier is Tricare/Humana, QualChoice, Prudential, BCBS or any HMO, you may need a referral from your primary care physician for your visit with UAMS. You will be expected to make a payment for any co-payment/deductible required by your particular plan at the time of the visit to our clinic. A referral from your primary care physician does not waive the necessity of these payments.

If you have Arkansas Medicaid, please provide us with your number at the time of your visit.

If you are a self-pay Health Department referral and meet qualifications for the "Women's Health Referral/Payment Agreement for Perinatal Health Services;" it is your responsibility to provide this paperwork at the time of your visit. Failure to do so may result in you being held responsible for payment. Contact your local health unit with any questions regarding this form.

If you have questions regarding your bill or insurance, please call to speak with the insurance coordinator at your scheduled clinic.

Telemedicine Clinic:
Nancy McDonald
501.526.4711

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Address:

UAMS

ANGELS

Antenatal & Neonatal Guidelines, Education & Learning System

Please remember to include a copy of *both* the front and the back of your insurance card!

Insurance Card FRONT	Insurance Card BACK

*Note: If we do not receive this information, the patient account will be the responsibility of the guarantor.

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Address:

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PATIENT INFORMATION

Please Print

PATIENT INFORMATION

SS# _____-_____-_____ ☐ MALE ☐ FEMALE DATE OF BIRTH _____ / _____ / _____

RACE: ☐ AMERICAN INDIAN ☐ BLACK ☐ HISPANIC ☐ ASIAN ☐ WHITE ☐ OTHER _____

RELIGION _____ E-MAIL ADDRESS _____

PATIENT'S LEGAL NAME _____
LAST FIRST MI MAIDEN

ALIAS _____ PHONE # (_____) _____

ADDRESS _____ APT.# _____

CITY _____ STATE _____ ZIP _____ COUNTY _____ COUNTRY _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

PATIENT'S EMPLOYMENT

EMPLOYER _____ OCCUPATION _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE # (_____) _____

EMPLOYMENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ RETIRED ☐ DISABLED HIRE/RETIRE DATE _____ / _____ / _____

GUARANTOR INFORMATION

PERSON RESPONSIBLE FOR BILL _____

SS# _____-_____-_____ ☐ MALE ☐ FEMALE DATE OF BIRTH _____ / _____ / _____

RACE: ☐ AMERICAN INDIAN ☐ BLACK ☐ HISPANIC ☐ ORIENTAL ☐ WHITE ☐ OTHER _____

PHONE # (_____) _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ APT.# _____

CITY _____ STATE _____ ZIP _____ COUNTY _____ COUNTRY _____

GUARANTOR'S EMPLOYMENT HISTORY

EMPLOYER _____ OCCUPATION _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ WORK PHONE # (_____) _____

EMPLOYMENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ RETIRED ☐ DISABLED HIRE/RETIRE DATE _____ / _____ / _____

SPOUSE OR NEAREST RELATIVE

NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE # (_____) _____

EMPLOYER _____ OCCUPATION _____

WORK ADDRESS _____ CITY _____ STATE _____ ZIP _____

WORK PHONE # (_____) _____ HIRE/RETIRE DATE _____ / _____ / _____

ACCIDENT INFORMATION

PLACE OF ACCIDENT _____ DATE OF ACCIDENT _____/ _____/ _____

TYPE OF ACCIDENT: ☐ EMPLOYMENT ☐ CRIME ☐ AUTO ☐ OTHER _____ NATURE OF ACCIDENT _____

IS THIS WORKER'S COMPENSATION? ☐ YES ☐ NO IF YES, WHO DO WE CONTACT? _____

CONTACT NAME _____ PHONE # (_____) _____

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Address:

UAMS
Medical Center

Please Print

EMERGENCY CONTACT

EMERGENCY CONTACT (OTHER THAN NEAREST RELATIVE)

NAME _____ RELATIONSHIP TO PATIENT _____

HOME PHONE # (_____) _____ WORK PHONE # (_____) _____

REFERRING PHYSICIAN

PHYSICIAN'S NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

OFFICE PHONE # (_____) _____

PRIMARY CARE PHYSICIAN (PCP) OR FAMILY PHYSICIAN

PHYSICIAN'S NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

OFFICE PHONE # (_____) _____

MEDICARE / MEDICAID INFORMATION (COMPLETE SECTION IF COPIES OF INSURANCE CARDS ARE NOT AVAILABLE)

MEDICARE # _____ PART A - EFFECTIVE DATE ____/____/____

PART B - EFFECTIVE DATE ____/____/____

MEDIPAK ID # _____ EFFECTIVE DATE ____/____/____ PLAN _____

MEDICAID # _____ EFFECTIVE DATE ____/____/____

INSURANCE (COMPLETE SECTION IF COPIES OF INSURANCE CARDS ARE NOT AVAILABLE)

PRIMARY
INSURANCE COMPANY _____ PHONE # (_____) _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ POLICY HOLDER'S SSN _____

POLICY HOLDER'S NAME _____ ID # _____ DATE OF BIRTH ____/____/____

GROUP NAME _____ GROUP # _____ EFFECTIVE DATE ____/____/____

IS A REFERRAL/PRE-AUTHORIZATION REQUIRED? ☐ YES ☐ NO IF YES, REFERRAL/AUTHORIZATION # _____

SECONDARY
INSURANCE COMPANY _____ PHONE # (_____) _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ POLICY HOLDER'S SSN _____

POLICY HOLDER'S NAME _____ ID # _____ DATE OF BIRTH ____/____/____

GROUP NAME _____ GROUP # _____ EFFECTIVE DATE ____/____/____

IS A REFERRAL/PRE-AUTHORIZATION REQUIRED? ☐ YES ☐ NO IF YES, REFERRAL/AUTHORIZATION # _____

STATEMENT OF CERTIFICATION

I CERTIFY THAT ALL INFORMATION ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE _____ DATE ____/____/____

TIME ____:____

UAMS
Medical Center

Authorization and Consent for Third Party Patient Account Responsibility

To Be Completed By Patient:

I hereby authorize and give consent for billing statements of my treatment by UAMS to be mailed to the person named below, at the address indicated below. I understand that the billing statement includes a description of services provided. I further understand that this person will accept full responsibility as the Guarantor of my patient account to pay any balance remaining after insurance has paid.

Name of Designated Account Guarantor (Please Print)

Address to which account statements are to be mailed (Please Print)

City State Zip Code

Signature of Patient or Guardian Date Time

To Be Completed by Designated Account Guarantor, if the Patient is not the Guarantor:

I agree to accept full financial responsibility for charges incurred by the above named patient for services rendered by UAMS. I agree to pay such charges or any balance remaining after the patient's insurance has paid.

Signature of Account Guarantor Date Time

(Place MR Label Here)

MR#:

Patient's Name:

Patient's Address:

UAMS
Medical Center

Authorization & Consent to Videoconference(s) with the ANGELS Telemedicine Clinic

Patient's Name: _____

Consent is good for videoconferences to end _____, 20___

I understand that my image and my Protected Health Information will be transmitted electronically through the videoconference(s) to physicians, healthcare professionals and to other UAMS personnel.
I understand that the individuals receiving my information are authorized to receive the information.
I understand that the information received is for the purpose of providing medical diagnostic assessment and treatment services to me.
I understand that the risk of unauthorized persons intercepting the transmission is extremely small.
I understand that any videotape(s) which are recorded will not disclose my identity and will be used only for data collection, research and educational purposes.

I understand that I may withdraw my permission at any time prior to the videoconference or during the videoconference(s).
I understand that no action will be taken against me for withdrawing my permission.
I understand that if I interrupt the videoconference, it will be incomplete and cannot be used to provide treatment or services for my current condition.
I understand that I may still get a consultation with a doctor or other healthcare professional.

I understand that there are limits to Telemedicine technology, therefore, there is no guarantee that this Telemedicine session will get rid of the need for me to see a doctor in person in order to receive appropriate or additional treatment for my current condition.

I have received and read the ANGELS Telemedicine Information sheet.
I have read this Authorization.
I have had the opportunity to ask questions and am satisfied with the answers.

I give my consent to participate in the UAMS ANGELS Telemedicine videoconference(s).

_____ _____ _____
Patient/ Legal Representative's Signature Date Time

_____ _____
Printed Name of Patient/Legal Representative Witness' Signature

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Address:

UAMS

Genetics Patient History and Pregnancy Sheet

Patient Name: _____
(Last) *(First)* *(Middle)* *(Maiden)*

Patient Address: _____

Father of Baby: _____
(Last) *(First)* *(Middle)*

Referring Physician / Office: _____

	Patient:	**Father of Baby:**
Social Security#:		
Date of Birth:		
Education completed:		
Occupation:		
Home#:		
Message#:		
Work#:		
	[ ] Single [ ] Married [ ] Divorced	[ ] Single [ ] Married [ ] Divorced
	Income: [ ] < 10,000 [ ] 10-19,000 [ ] 20-29,999 [ ] 30-39,999 [ ] > 40,000	Income: [ ] < 10,000 [ ] 10-19,000 [ ] 20-29,999 [ ] 30-39,999 [ ] > 40,000

Please indicate by circling appropriate racial/ethnic group(s):
Patient: Black/African-American Hispanic Jewish White/Caucasian Greek/Italian/Mediterranean Asian Celtic (British Isle) Other _____
Father: Black/African-American Hispanic Jewish White/Caucasian Greek/Italian/Mediterranean Asian Celtic (British Isle) Other _____
Are you and the father related by blood: [ ] yes [ ] no

Please check yes or no if any of the following apply to you or the father of the baby: *Result if "yes"*

[ ] yes [ ] no Tested for Sickle Cell (Black/African-American descent)? _____
[ ] yes [ ] no Tested for Tay Sachs (Jewish descent)? _____
[ ] yes [ ] no Tested for Thalassemia/anemia (Italian/Greek/Asian descent): _____

Number of times pregnant including this pregnancy: _____ Date of last menstrual period: _____
Do you or the father of the baby have any health problems?

During THIS pregnancy have you had:

[ ] yes [ ] no medications
[ ] yes [ ] no recreational drugs
[ ] yes [ ] no alcohol
[ ] yes [ ] no diabetes
[ ] yes [ ] no cigarettes
[ ] yes [ ] no spotting/bleeding
[ ] yes [ ] no severe vomiting
[ ] yes [ ] no high fever
[ ] yes [ ] no rashes, infection
[ ] yes [ ] no other problems

Please Explain "YES" Answers

_____
_____
_____
_____
_____

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Address:

UAMS

Genetics Patient History and Pregnancy Sheet

Have you, the father of the baby, or anyone in your families ever had the following condition?

[ ] yes	[ ] no	Down syndrome	[ ] yes	[ ] no	kidney problems	[ ] yes	[ ] no	miscarriage
[ ] yes	[ ] no	other chromosome problem	[ ] yes	[ ] no	heart defect at birth	[ ] yes	[ ] no	stillborn
[ ] yes	[ ] no	spina bifida (open spine)	[ ] yes	[ ] no	mental retardation	[ ] yes	[ ] no	any child who died
[ ] yes	[ ] no	hemophilia/bleeding disorder	[ ] yes	[ ] no	neurofibromatosis	[ ] yes	[ ] no	other inherited condition
[ ] yes	[ ] no	cystic fibrosis	[ ] yes	[ ] no	sickle cell anemia/trait	[ ] yes	[ ] no	any birth defect
[ ] yes	[ ] no	thalassemia	[ ] yes	[ ] no	cleft lip/cleft palate	[ ] yes	[ ] no	previous genetic testing
[ ] yes	[ ] no	hydrocephalus (water on brain)	[ ] yes	[ ] no	muscular dystrophy			

Please Identify and Explain Any "YES" Answers

_____

_____

_____

_____

_____

_____

If a family member is deceased, please list age at death and cause, if known. If a family member has/had cancer, list type/age of onset. _____

List age of children, sex, and any health problems (please do not use names):

Yours from previous relationship	Father's from a previous relationship	Yours with father of this baby
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List age and any health problems of YOUR family members (please do not use names)

Father: _____

Mother: _____

Brother(s)/sister(s)	half	full	Brother(s)/sister(s)	half	full
_____	[ ]	[ ]	_____	[ ]	[ ]
_____	[ ]	[ ]	_____	[ ]	[ ]
_____	[ ]	[ ]	_____	[ ]	[ ]
_____	[ ]	[ ]	_____	[ ]	[ ]
_____	[ ]	[ ]	_____	[ ]	[ ]

List age and any health problems of family members of father of baby (please do not use names)

Father: _____

Mother: _____

Brother(s)/sister(s)	half	full	Brother(s)/sister(s)	half	full
_____	[ ]	[ ]	_____	[ ]	[ ]
_____	[ ]	[ ]	_____	[ ]	[ ]
_____	[ ]	[ ]	_____	[ ]	[ ]
_____	[ ]	[ ]	_____	[ ]	[ ]
_____	[ ]	[ ]	_____	[ ]	[ ]

Please list any additional information in this space -> _____

_____

_____

_____

_____

_____ _____ _____

Signature Date Time

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Address:

UAMS

ANGELS Program Evaluation

Consult Date: ☐☐ ☐☐ ☐☐☐☐ Consult Number: ☐☐☐☐☐ Pt. ID: ☐☐☐☐☐
For Telehealth Office Use Only

Patient: ☐☐☐☐☐☐ Please put the first initial of first name, the first initial of middle name and the first 4 letters of last name.
Example: John Paul George would be GPGEOR. If you do not have a middle name plase use an X.

Patient Name: (write full name as: Last Name, comma First Name space Middle Name or Initial. Exp: Smith, Jane T (do not use periods)

SSN: ☐☐☐☐☐☐☐☐☐ Date of Birth: ☐☐ ☐☐ ☐☐☐☐

Address (Please separate with spaces, no periods)

City: State:

Zip: County: Phone:

Sex: [ ] female [ ] male Have you ever been a patient at UAMS? [ ] yes [ ] no

Marital Status: [ ] single [ ] married [ ] divorced [ ] widowed

1. What is your race/ethnic group: [ ] African-American (black) [ ] American Indian, Alaskan Native, Alout
   [ ] Caucasion (white) [ ] Hispanic [ ] other:
2. What is your primary health insurance? [ ] none [ ] Medicaid [ ] Medicare [ ] CHAMPUS
   [ ] Commercial Insurance - Managed Care (HMO) [ ] Other commercial insurance [ ] not applicable
   [ ] other:
   Policy Number:
   Name of Commercial Insurance Company
   Insurance Company Address
   Insurance Company City, State, Zip
3. What type of work do you do? [ ] retail or wholesale trade [ ] manufacturing [ ] Mining or construction
   [ ] agriculture, forestry or fishing [ ] retired [ ] finance, insurance or real estate [ ] state government
   [ ] unemployed [ ] local government [ ] transportation, communications or utilities [ ] health care related
   [ ] other:
4. In which of the following categories does your household's annual income fall? [ ] up to $25,000 [ ] $25,001 to $50,000
   [ ] $50,001 to $100,000 [ ] more than $100,000 [ ] decline to answer [ ] not applicable (e.g., child, student)
5. How much schooling have you completed? (check most advanced level) [ ] less than high school diploma [ ] GED or high school diploma
   [ ] some college/vocational school bechelor's degree [ ] graduate degree [ ] decline to answer
6. How familiary are you with telemedicine? (check the answer you most agree with) [ ] I've had other telemedicine visits
   [ ] I know what telemedicine is, but I've never used it until today [ ] I've heard of telemedicine, but I don't know what to expect for today's visit
   [ ] I don't know anything about telemedicine
7. How many people live in your household, including yourself? ☐☐

(Place MR Label Here)
MR#:
Patient's Name:
Patient's Address:

UAMS

ANGELS Program Evaluation

Consult Date: [ ][ ] [ ][ ] [ ][ ][ ][ ]	Consult Number: [ ][ ][ ][ ][ ]	Pt. ID: [ ][ ][ ][ ][ ]
	For Telehealth Office Use Only	
Patient: [ ][ ][ ][ ][ ][ ]	Please put the first initial of first name, the first initial of middle name and the first 4 letters of last name. Example: John Paul George would be GPGEOR. If you do not have a middle name plase use an X.	

1. Have you ever used telemedicine before? (mark only one)
   [ ] yes, nore than 5 times [ ] yes, 1-5 times [ ] no

2. Were you given a good explanation of what to expect before the session began? (mark only one):
   [ ] yes [ ] no [ ] not applicable

3. Were you communication with a provider on a TV monitor, or over the telephone, during your session?
   [ ] yes, on a TV monitor [ ] yes, over the telephone [ ] no (go to question #8)

	strongly disagree	disagree	undecided	agree	strongly agree
4. I was satisfied with the picture quality:	[ ]	[ ]	[ ]	[ ]	[ ]
5. I was satisfied with the sound quality	[ ]	[ ]	[ ]	[ ]	[ ]
6. I was satisfied with my talk with the provider	[ ]	[ ]	[ ]	[ ]	[ ]
7. I talked about my concerns openly	[ ]	[ ]	[ ]	[ ]	[ ]
8. I did not have to wait too long to see the provider	[ ]	[ ]	[ ]	[ ]	[ ]
9. I felt comfortable during the visit	[ ]	[ ]	[ ]	[ ]	[ ]
10. I have been told when to expect the results of this session	[ ]	[ ]	[ ]	[ ]	[ ]
11. I know whom to contact with any questions related to today's session	[ ]	[ ]	[ ]	[ ]	[ ]
12. I was satisfied with the quality of care I received today	[ ]	[ ]	[ ]	[ ]	[ ]
13. Overall, I was satisfied with today's session	[ ]	[ ]	[ ]	[ ]	[ ]
14. After today's session, I am more willing to use telemedicine if my doctor recommends it	[ ]	[ ]	[ ]	[ ]	[ ]

15. To attend this session, I traveled (choose only one):
   [ ] less than 30 miles [ ] 31-50 miles [ ] 51-70 miles [ ] more than 70 miles

16. I prefer having a telemedicine session rather than seeing the provider in person
   [ ] strongly disagree [ ] disagree [ ] undecided [ ] agree [ ] strongly agree

17. If I did not use this telemedicine session for treatment, I would have to travel (choose only one):
   [ ] less than 30 miles [ ] 31-50 miles [ ] 51-70 miles [ ] more than 70 miles

18. If I did not use this telemedicine session fro treatment, the cost of traveling to a specialist, missing work and other expenses for me and my family would be (choose only one):
   [ ] a) less than $35.00 [ ] b) $35.00-$75.00 [ ] c) $75.00 - $150.00 [ ] d) $150 - $300 [ ] e) more than $300.00

19. If I did not use this telemedicine session for treatment, I would have to miss work for (choose only one):
   [ ] no days [ ] 1/2 day [ ] 1 day [ ] 2 days [ ] more than 2 days

20. Without telemedicine, I would not have received medical care for this problem.
   [ ] strongly disagree [ ] disagree [ ] undecided [ ] agree [ ] strongly agree