Cardiovascular and Thoracic Surgery
Washington Regional

Dear valued patient,

We are located at 3276 N. North Hills Blvd, Fayetteville, AR 72703 (Across from Washington Regional Medical Center in the green-roofed buildings that share the same parking lot as Highlands Oncology).

Enclosed is our paperwork so you can fill this out completely in the comfort of your home with your records and medications readily available. PLEASE, DO NOT MAIL THESE FORMS TO OUR OFFICE.

Upon arrival, please give the receptionist the following:

* Your completed paperwork (if enclosed)
* A list of current medications (or bring your medication bottles for nurse review)
* Driver's License or Picture ID
* Medical Insurance Cards
* Any co-pay, deductible, or amount not covered by insurance
* Any CDs or test results (will become permanent record in chart)

Patients who have a **post-operative or follow-up appointment** might see the Doctor of Nursing Practice (DNP) or Physician Assistant (PA).

Patients who are scheduled for **testing** such as an ultrasound will only see the Vascular Technician. Test results may take 7-10 business days.

To keep your wait time to a minimum, **please do not show up more than 20 minutes** prior to your appointment. As a reminder, this is a surgery clinic which means there is a chance of an emergency. In such as case, we will do our best to see our patients in a timely fashion.

It is important that you call 24 hours in advance to cancel your appointment. If for any reason, you need to cancel or reschedule an appointment please notify our office as a soon as possible. On the second no-show or same-day cancellation/reschedule occurrence, there will be a **$45 charge** not covered by insurance. After three consecutive no-show occurrences, the practice reserves the right to terminate our relationship.

If you have any questions or need directions, please contact our office. We look forward to your visit.

Sincerely,
Management

Please visit us at www.facebook.com/nwacardio for events and updates

Cardiovascular and Thoracic Surgery
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RUSSELL H. WOOD, M.D.
JAMES S. COUNCE, M.D.
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3276 N. North Hills Blvd
Fayetteville, AR 72703
Office: 479-404-2110
Fax: 479-404-2111

NAME : _____ **BIRTHDATE:** _____

ADDRESS: _____

IF PO BOX, 911 ADDRESS: _____

HOME PH# _____ **CELL PH#:** _____

EMAIL ADDRESS: _____ **MARITAL STATUS:** _____

CONTACT PREFERENCE: □ BY PHONE □ BY EMAIL □ BY PHONE & EMAIL □ DO NOT CONTACT

EMPLOYER NAME: _____ **EMPLOYER PH#:** _____

EMPLOYMENT: □ FULL TIME □ PART TIME □ NOT EMPLOYED □ SELF EMPLOYED □ RETIRED □ MILITARY DUTY

GENDER: □ MALE □ FEMALE □ NEUTRAL □ BORN MALE/CURRENT FEMALE □ BORN FEMALE/NOW MALE

RACE: □WHITE □AFRICAN AMERICAN □ASIAN □NATIVE HAWAIIAN/PACIFIC ISLANDER □ AMERICAN INDIAN/ALASKAN □HISPANIC □UNKNOWN □DECLINE

ETHNICITY (ORIGIN): □ NOT HISPANIC OR LATINO □ HISPANIC OR LATINO □ UNKNOWN □ DECLINE

EMERGENCY CONTACTS

In order to protect your privacy, Cardiovascular and Thoracic Surgery Clinic asks you to list the family member, friends or any person(s) (***including but not limited to spouses, significant others, and legal representatives***) who we may contact or can request or inquire regarding your Protected Health Information which includes medical condition and/or billing and financial information.

1. **NAME** _____ **RELATIONSHIP** _____ **PHONE** _____
   ADDRESS _____
2. **NAME** _____ **RELATIONSHIP** _____ **PHONE** _____
   ADDRESS _____
3. **NAME** _____ **RELATIONSHIP** _____ **PHONE** _____
   ADDRESS _____

PHYSICIAN CARE TEAM

PRIMARY CARE PHYSICIAN NAME: _____ **PHONE** _____

ADDRESS: _____

SECONDARY CARE PHYSICIAN NAME: _____ **SPECIALITY:** _____

ADDRESS & PHONE NUMBER: _____

ADDITIONAL CARE PHYSICIAN NAME: _____ **SPECIALITY:** _____

ADDRESS & PHONE NUMBER: _____

PHARMACY

NAME: _____ **PHONE** _____

ADDRESS: _____

MAIL-ORDER PHARMACY NAME: _____

MAIL-ORDER PHARMACY ADDRESS: _____

Please bring your medications, or a list of them, to your office visit and ask your doctor to write refills for any medications you anticipate needing.

Patients who have been seen by the doctor at appropriate intervals may call for refills on some prescriptions (antibiotics excluded). You may call your pharmacy 2 - 3 days prior to running out of medication so the pharmacy can fax a refill request to the clinic. Please allow 48 hours for refill requests. Requests received after 2 p.m. will be not be reviewed until the next business day. No pain medication prescriptions will be written on Friday. Most pain medication prescriptions will require the patient or respresentative to pick up from our office. Please bring a photo ID at the time of pick up.

Patients who use a mail order pharmacy plan will need to pick up written prescriptions from the clinic and mail them to their providing pharmacy.

SIGNATURE: _____ **Date:** _____

Please bring the following to your appointment: Insurance cards & picture I.D, all medications or a list of medications, CD of testing if indicated (note: CDs will become patient records and not subject to return). Co-pay & co-insurance due at the time of appointment

NAME: _____ **DOB:** _____

PAST MEDICAL HISTORY:

☐Arthritis	☐Diabetes	☐High Cholesterol	☐Prostate Problem
☐Asthma	☐Emphysema	☐HIV Positive	☐Rheumatic Fever
☐Atrial Fibrillation	☐Fibromyalgia	☐Kidney Disease	☐Seizures
☐Bleeding Disorders	☐Glaucoma	☐Liver Disease	☐Stroke
☐Bronchitis	☐Gout	☐Multiple Sclerosis	☐Thyroid Problems
☐Cancer	☐Heart Attack	☐Pacemaker	☐Tuberculosis
☐Congestive Heart Failure	☐Hepatitis	☐Pneumonia	☐Ulcers

Other_____

PAST SURGICAL HISTORY:

LIST ALL SURGERIES AND APPROXIMATE DATE

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

SOCIAL HISTORY:

Married, Widowed, Single or Divorced (circle one) Number of children:_____ Age(s) of Child(ren): _____

Who lives in your home? _____

Do you smoke? Yes_____ No_____ How much?_____

Tobacco, E-cigarettes, or Vape (circle) How long?_____

Did you ever smoke? Yes_____ No_____ When did you quit?_____

Tobacco, E-cigarettes, or Vape (circle) How much?_____

How long?_____

Do you drink alcohol? Yes_____ No_____ If yes, how much?_____

Do you use illegal drugs? Yes_____ No_____ If so, what kind?_____

Are you concerned that you may have been exposed to HIV? Yes_____ No_____

Employed, Unemployed, Retired, Disabled ? (circle one)

What type of work do you currently do/retired from? _____

Religious Preference? _____ Highest Level of Education? _____

Native Language? _____ Amount of family or social support? (Good/Poor/None) _____

FAMILY HISTORY:

Member	Age	State of Health	Age at Death	Cause
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
	_____	_____	_____	_____

Reviewed by/Credentials: _____ Date: _____

NAME: _____ **DOB:** _____

MEDICATIONS:

(Please list all of your medications including inhalers, as well as vitamin and herb supplements.) Include name of medication, dose and number of times taken per day.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

PHARMACY: (Please complete in full)

Name: _____ **Phone #:** _____

Pharmacy Address: _____

Mail-order Pharmacy Name: _____

Mail-order Pharmacy Address: _____

ALLERGIES: (Please list all of your medication allergies or write "No Known Allergies".)

_____ _____ _____
_____ _____ _____
_____ _____ _____

REVIEW OF SYSTEMS:

Have you had any recent weight **gain** or **loss** (circle) …… How many pounds_____Period of time_____
Have you had any unusual weakness or fatigue? Yes_____No_____
Do you have any **fever**, **chills** or **night sweats**? (circle) Yes_____No_____
Do you have any **dizziness, vision change** or **headaches**? (circle) Yes_____No_____
Do you have a hearing aid or hearing loss? (circle) Yes_____No_____
Do you have any nose **drainage** or **bleeding**? (circle) Yes_____No_____
Do you have any difficulty swallowing? Yes_____No_____
Do you have any hoarseness? Yes_____No_____
Do you have any unusual sinus problems? Yes_____No_____
Do you have any shortness of breath **with** or **without** exertion? (circle) Yes_____No_____
Do you have difficulty breathing while lying down? Yes_____No_____
Do you awaken at night short of breath? Yes_____No_____
Have you had any wheezing? Yes_____No_____
Have you coughed up **blood** or **sputum** recently? (circle) Yes_____No_____
Do you have any chest pain? Yes_____No_____
Have you had any loss of consciousness recently? Yes_____No_____
Have you had any pounding or racing of the heart? Yes_____No_____
Have you had any chest tightness or squeezing? Yes_____No_____
Have you had any **nausea** or **vomiting?** (circle) Yes_____No_____
Have you had any rectal bleeding, black or tarry stools? Yes_____No_____
Does it **burn** when you urinate or is there **blood** in your urine? (circle) Yes_____No_____
Do you have any muscle or back pain? Yes_____No_____
Have you had any cramps, pain or swelling in your legs? Yes_____No_____
Do you have any pain in your legs when you walk? (describe) _____
Do you have any color change in any of your extremities? Yes_____No_____
Do you have any unusual skin rashes or itching? Yes_____No_____
Have you had any changes in your speech or memory? Yes_____No_____
Have you had any seizures? Yes_____No_____
Have you been stressed, nervous, depressed? Yes_____No_____
Have you had any unusual bleeding? Yes_____No_____
Have you had any unusual swelling in the **glands of your neck**, **under your arms**, or in your **groin**? (circle) Yes_____No_____

Reviewed by/Credentials: _____ Date: _____

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PATIENT NAME: _____ **DATE OF BIRTH:** _____

MEDICARE POLICY

I request that payment of authorized Medicare benefits be made on my behalf to Cardiovascular Thoracic Surgical Clinic for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its' agents any information needed to determine these benefits or the benefits payable for related services.

PAYMENT POLICY

Insurance Co-pays/co-insurance monies are due upfront at time of service. After all insurance monies have been received; you are immediately responsible for full payment of any remaining balance. If full payment cannot be made, it is your responsibility to contact the business office at 479-463-6000 to discuss a payment plan. YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the information on this sheet and have completed the answers on the first page. I certify this information is true and correct to the best knowledge. I will notify you of any changes in health status or the personal information.

Any information given to use will be used if needed to collect on a debt. We reserve the right to report delinquent balances to credit bureaus. We reserve the right to use a third-party collections agency, seek legal action, and/or petition the IRS under debtor intervention that may include IRS review/audit or a tax lien. We reserve the right to discontinue providing medical care if we are unable to collect for our services in a timely manner.

MEDICAL RECORDS POLICY

A medical request signed by the patient is required to send or release records to anyone other than a medical provider listed on the care team. If you are requesting a copy of your records, there will be a fee of $6.50 for records picked up/faxed/e-mailed. For records mailed, the cost is $6.50 plus the amount of postage due prior to records sent.

AUTHORIZATION RELEASE

*** I authorize release of any medical information necessary to process my claim to all my insurance companies.**

*** I authorize direct payment of medical benefits to the provider**

*** I permit of copy of this authorization to be used in place of the original**

*** I consent for my photo to be taken**

*** I understand I am responsible for any amount not covered by insurance**

*** I permit the faxing and electronic transmission of medical information to other health care providers involved in my care**

*** I give my permission for messages to be left on my answering machine or sent by e-mail**

*** I authorize and consent to the rendering of medical care, including diagnostic procedures, and medical treatment by authorized members of this facility, or their designees, as may in their professional judgement be necessary for the above named patient. I acknowledge that no guarantees have been made as to the effect of such examinations of treatment.**

*** I received a copy of the Notice of Privacy Practices for this facility and may request an additional copy at any time**

*** I permit this facility to obtain my medication history electronically**

*** I authorize WRMC operators in their role as an answering service to release my protected health information utilizing the pager system or text messaging**

*** I authorize this facility to discuss my information with:**

Name: _____ **Relation:** _____ **Phone#:** _____

Name: _____ **Relation:** _____ **Phone#:** _____

Name: _____ **Relation:** _____ **Phone#:** _____

Signature :_____ **Date:** _____

(Patient signature but parent signature if patient under 18 years of age)

Patient Representative (if applicable): _____

Relation of Representative: _____