Washington Regional

Welcome to the Washington Regional Senior Health Clinic

All our doctors are Board Certified Geriatric Physicians. We use a team-based approach to your care and our Nurse Practitioners are an integral part of your healthcare. If you need an urgent appointment and your doctor is not available, then you may see your team Nurse Practitioner or Physician Assistant. The best way to contact your team or physician for questions is to call 479-463-4444 and ask for your doctor's nurse. Our nurses check messages throughout the day and will forward them to your doctor if they cannot answer them.

If you need admission to the hospital, you will be admitted by the WRMC hospitalist team or specialist; you will not be admitted by our doctors. The type of expertise needed to care for patients in the hospital is different from the skills needed to take care of the patients in the office. Washington Regional has developed a hospitalist program with highly qualified physicians who will efficiently deliver your care, communicate with us during your stay, and have you return to see us for your follow-up care after your hospitalization.

The Senior Health Clinic, the Memory Disorders Clinic, and the Movement Disorders Clinic, all part of the Washington Regional Pat Walker Center for Seniors, have become outpatient departments of the Washington Regional Medical Center as of August 1st, 2023. Hospital outpatient departments, also known as hospital-based outpatient clinics, are common models used by healthcare systems in our region, state, and throughout the country. As a hospital-based outpatient clinic, the clinic will be subject to additional safety and quality measures applicable to hospitals.

This Medicare-approved model allows Washington Regional to be compensated for the unique services offered by our clinic, including providers and nurses who have specialized training in caring for seniors and adults with memory or movement disorders, as well as exceptional care managers and social workers. This will be billed to your insurance as a hospital/facility fee and is separate from the fee for provider services. This fee applies to both in-person and telemedicine visits but does not apply to laboratory services or Medicare annual wellness visits.

Depending on your individual plan and time of year when seen, the hospital/facility fee could range between $106-$118 if you have not met your annual deductible. You should check with your insurance carrier to determine if your plan covers hospital/facility charges in hospital-based outpatient clinics. Please reference CPT code "G0463" when speaking to your insurance carrier. Additionally, all lab draws, whether performed on the day of your appointment or prior to your appointment, will need to be drawn at the Senior Health Clinic. We are unable to send our physician's lab orders to outside facilities or draw other provider's labs within our clinic.

We look forward to collaborating with you.

Respectfully,

Washington Regional Senior Health Clinic

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WHAT TO EXPECT NEXT

- The new patient packet must be received within 24 hours before your appointment, or it will be rescheduled.
- Please be aware that your appointment can last up to 2 hours.
- You must bring all medications except for refrigerated medications.
- Insurance cards are required at the time of check-in.
- All appointments must be confirmed at least a day before or you may run the risk being cancelled.

CANCELLATION POLICY/ NO SHOW POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel or do not show to your appointment, you may be preventing another patient from getting needed treatment. Appointments are in high demand your early cancellation is appreciated.

Due to an exceedingly "full" appointment book, we require at least 24-hour notice to cancel or reschedule an appointment. If a cancellation occurs within 24 hours of an appointment, the patient will be recorded as a "No Show". If proper notice is not given ***two times***, you will receive a verbal warning about the possibility of being discharged from our practice for failure to follow this policy a third time.

Failure to be present at the time for a scheduled appointment will be recorded in your medical record as a "No Show". This could potentially cause you to be discharged from our practice.

This policy enables us to better utilize available appointments for our patients in need of medical care.

New Patients will not be allowed to reschedule a No-Show appointment, or if the appointment has been rescheduled twice.

Please call 479-463-4444 if you wish to reschedule. You may leave a detailed message on our voicemail, please leave your name, date of birth and a good call back number. We will return your call and give you the next available appointment time.

I have read and agree with the above Cancellation Policy.

Signed: _____ Date: _____

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Our clinic participates in a special Medicare Program for older adults. This program ensures we adhere to recognized and best practice protocols for the care of older adults. This program has guidelines for prescription medications, primarily those associated with poor outcomes in older adults.
We DO NOT prescribe certain classes of medications. The following medications are examples of medications we do not prescribe, for long term use.

Chronic Pain Medications and Muscle Relaxants: Opioids such as Fentanyl (Actiq, Duragesic, Fentora), Hydrocodone (Hysingla ER, Zohydro ER), Hydrocodone/Acetaminophen (Lorcet, Lortab, Norco, Vicodin), Hydromorphone (Dilaudid, Exalgo), Meperidine (Demerol), Methadone (Dolophine, Methadose), Morphone (Astramorph, Avinza, Kadian, MS Contin, Ora-Morph SR), Oxycodone (Percocet, Endocet, OxyContin, Oxecta, Roxicodone), Morphine (MS Contin), and/or muscle relaxers such as Carisoprodol (Soma).

Anxiety/Panic/Adult ADD/ADHD: Benzodiazepines such as Alprazolam (Niravam, Xanax, Xanax XR), Chlordiazepoxide (Librax), Clobazam (Onfi), Clonazepam (Klonopin), Clorazepate (Tranxene T-Tab), Diazepam(Valium), Estazolam (ProSom), Flurazepam (Dalmane), Lorazepam (Ativan), Midazoam (Versed), Oxazepam (Serax), Temazepam (Restoril), Triazolam (Halcion), Methyphenidate (Concerta, Ritalin, Daytana, Metadate CD, Methylin), Dextroamphetamine/Amphetamine (Adderall), Lisdexamfetamine (Vyvanse) or Mixed Salts Amphetamine (Adderall).

Weight Loss/Weight Gain Medications: Phentermine (Adipex-P), Megace (megestrol acetate), or Periactin

Narcolepsy/Sleep Apnea: Armodafinil (Nuvigil) or Modanfinil (Provigil)

Sleeping Aids or Sedatives: Ambien (Zolpidem), Lunesta (Eszopiclone), Sonata (Zaleplon), or Doxepin

I have read and understand the above agreement prior to seeing the physicians and providers at the Washington Regional Pat Walker Center for Seniors by signing below, I am verifying that I would like to be a patient of the Washington Regional Pat Walker Center for Seniors and that I understand my doctor ***will not*** *be prescribing or refilling any of the above medications. I agree that if I need such medications, I, will need to find another physician for treatment or agree to see a specialist who can prescribe the medication(s).*

_____

Print Patient Name

_____

Patient Signature Date

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Patient Demographic Information

Last name_____ First name_____ Middle initial _____
Street address _____ City _____ State_____ Zip code_____
Age_____ DOB _____SSN _____-_____-_____ Sex ☐ Male ☐ Female
Occupation_____ Employer _____ Full Time/Part-time
Is patient Retired ☐ YES ☐ NO Date of Retirement _____
Is patient a Veteran ☐ YES ☐ NO
Primary Phone# _____ Alternate Phone# _____
Marital status: ☐ Married ☐ Single ☐ Partner ☐ Divorced ☐ Widowed ☐ Separated
Ethnicity (Origin): ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Other ☐ Decline
Race _____ Preferred Language _____
Email address _____
Preferred method of communication: Cellphone ☐ Home Phone ☐ Email ☐
Preferred Pharmacy _____

Guarantor Information

Is the patient the guarantor? ☐ YES ☐ NO (If yes please leave the remainder of this section blank)
Last name_____ First name_____ Middle initial _____
Street address _____ City _____ State_____ Zip code_____
Age_____ DOB _____SSN _____-_____-_____ Sex ☐ Male ☐ Female
Occupation_____ Employer _____
Primary Phone# _____ Alternate Phone# _____
Patient signature _____
If patient is unable to sign, Power of Attorney document must be provided authorizing the above named as a legal guarantor.

Please list all individuals who may have access to the patient's personal health information:
Name _____ Relationship to patient _____ Phone# _____
Name _____ Relationship to patient _____ Phone# _____
Name _____ Relationship to patient _____ Phone# _____

Who should we contact in case of an emergency?
Last name _____First name _____ DOB _____
SSN _____-_____-_____ Sex ☐ Male ☐ Female Relationship to patient _____
Primary Phone # _____ Employer _____

I certify that the above information is accurate.
Authorized guarantor signature _____ Date _____

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Primary Insurance

Patient's relationship to the Main Policy Holder ☐ Myself ☐ Spouse ☐ Other _____
Insurance ID # _____
Name of Insurance Company _____
Insurance Company Address _____
City _____ State _____ Zip code _____
Insurance Company's Phone Number _____
Main Holder's Name _____ Main Holder's Date of Birth _____
Main Holder's Address _____ Main Holder's SSN _____
City _____ State _____ Zip code _____

Secondary Insurance

Patient's relationship to the Main Policy Holder ☐ Myself ☐ Spouse ☐ Other _____
Insurance ID # _____
Name of Insurance Company _____
Insurance Company Address _____
City _____ State _____Zip code _____
Insurance Company's Phone Number _____
Main Holder's Name _____ Main Holder's Date of Birth _____
Main Holder's Address _____ Main Holder's SSN _____
City _____ State _____ Zip code _____

Other Information:

Name of person filling out this form: _____
Relation to Patient _____How did you hear about this clinic _____
Current primary care doctor _____Last visit with primary doctor _____
Comments or concerns about patient's health:
_____

List Primary Care Physician and Specialist

Name Phone Number Address

_____

_____

_____

_____

_____

_____

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Medical History

Please Check All that Apply

- ☐ Asthma
- ☐ Allergies_____
- ☐ Anemia
- ☐ Atrial Fib.
- ☐ Blood Clot, Specify:_____
- ☐ Cancer, Type_____
- ☐ Congestive Heart Failure
- ☐ Dementia
- ☐ Diabetes
- ☐ Emphysema/Chronic Bronchitis
- ☐ Fainting/Dizziness
- ☐ Frequent/Severe Headaches
- ☐ Hearing issues, specify:_____
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Other _____
- ☐ High Cholesterol
- ☐ Involuntary movement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Memory Problems
- ☐ Osteoporosis/Broken Bones
- ☐ Pneumonia
- ☐ Rheumatoid disease
- ☐ Seizures
- ☐ Sleep Apnea: CPAP? ☐ YES ☐ NO
  DME Company _____
- ☐ Stroke/CVA
- ☐ Tremor
- ☐ Varicose Veins
- ☐ Vision issues, specify:_____

What Surgeries Have You Had

Type and Location (i.e. left or right) Date Hospital

_____

_____

_____

_____

_____

List All Hospitalizations Within the Last Five Years:

Reason Date Hospital

_____

_____

_____

_____

Senior Health Clinic

12 E. Appleby Rd. | Fayetteville, AR 72703 | 479.463.4444 phone | 479.463.4499 fax | wregional.com

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Psychiatric History

Have you had any nervous or psychiatric illness? ☐ Yes ☐ No

Current Medications: Please Bring All Your Medication with You

Medication Name	How much do I take at each dose?	When do I take it?	Why do I take it?

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Allergies

Medication/Food Reaction

_____

_____

_____

_____

_____

Health Maintenance

When and where did you have the following:

Tetanus vaccination _____ Flu vaccination _____

Pneumovax vaccination _____ COVID -19 vaccination _____

Prevenar vaccination _____ RSV vaccination _____

Shingrix vaccination _____ Tdap vaccination _____

Zostavax vaccination _____ Hepatitis B vaccination _____

Colonoscopy _____

Sleep Study _____

Bone Density _____

Stress Test _____

Eye Exam _____

Dental Exam _____

FOR WOMEN

Mammogram/breast examination _____

Pelvic exam/pap smear_____

Have you taken Hormones_____

FOR MEN

PSA_____ Prostate Exam_____

How do you feel about your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Has your cholesterol been checked? ☐ YES ☐ NO

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Social History

Education (highest grade completed) _____

Work history /former occupation _____

Are you retired? ☐ YES ☐ NO Month/Year: _____

Is patient a Veteran ☐ YES ☐ NO

Branch of the Service _____

Does the patient have VA benefits? ☐ YES ☐ NO

Do you engage in any exercise? ☐ YES ☐ NO

What are your current activities?

_____

_____

Do you follow any special diets? _____

What is your current living situation? Type of House: _____ With whom? _____

Have any friends or relatives died recently? _____

Are you having any severe financial difficulty? _____

Can you afford your medications? ☐ YES ☐ NO

Do you currently have home health? ☐ YES ☐ NO

Name of Company _____

Are you a caregiver to anyone in home/family? ☐ YES ☐ NO

Do you smoke cigarettes or use tobacco? ☐ YES ☐ NO Past years, but quit: _____

Do you drink alcohol, including beer, wine, or other alcohol? ☐ YES ☐ NO

If so what type and how often:

_____

If you drink alcohol, has anyone ever been concerned about your drinking? ☐ YES ☐ NO

Advance Directives

Have you appointed a durable power of attorney for health care decisions? ☐ YES ☐ NO

Do you have a living will? ☐ YES ☐ NO

If you were unable to make your own health care decisions, who would you trust to make these decisions on your behalf?

Name _____

Relationship _____

Address _____

Phone# _____

Do you have any opinions about cardiac resuscitation, mechanical ventilation, feeding tubes, or other medical interventions that we should know about?

_____

_____

_____

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Functional Assessment

Do you have any of the problems listed below:

Walking ☐ YES ☐ NO Comment:_____

Leakage of urine or bowel incontinence ☐ YES ☐ NO Comment:_____

Bathing yourself ☐ YES ☐ NO Comment:_____

Feeding yourself ☐ YES ☐ NO Comment:_____

Getting out of bed or chair ☐ YES ☐ NO Comment:_____

Using the telephone ☐ YES ☐ NO Comment:_____

Driving a car ☐ YES ☐ NO Comment:_____

Using public transportation ☐ YES ☐ NO Comment:_____

Doing your own shopping ☐ YES ☐ NO Comment:_____

Doing your own cooking ☐ YES ☐ NO Comment:_____

Doing your own cleaning ☐ YES ☐ NO Comment:_____

Managing your own finances ☐ YES ☐ NO Comment:_____

Taking your medications ☐ YES ☐ NO Comment:_____

Have you fallen or experienced falls in the last 6 months? ☐ YES ☐ NO

If yes, what were the circumstances of the fall? _____

Have you passed out or lost consciousness? ☐ YES ☐ NO

Do you use assistive device(s)? ☐ Cane ☐ Crutches ☐ Walker ☐ Dentures ☐ Prosthetic limb
☐ Hearing aid ☐ Splint/Brace ☐ Glasses ☐ Contacts ☐ Wheelchair ☐ CPAP ☐ Medical Implants

Family History

Please list current age and health status of family members, for deceased list a date of death and cause.

Mother _____

Father _____

Brother(s)_____

Sister(s) _____

Spouse_____

Children_____

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Review of Systems

Have you had a recent change in your weight? ☐ YES ☐ No
Comment: _____
Do you have problems with dizziness? ☐ YES ☐ No
Comment: _____
Are you depressed, sad or feeling blue? ☐ YES ☐ No
Comment: _____
Are you having problems falling asleep or staying asleep? ☐ YES ☐ No
Comment: _____
Are you having any memory problems? ☐ YES ☐ No
Comment: _____
Do you have problems with hearing? ☐ YES ☐ No
Comment: _____
Do you have vision problems? ☐ YES ☐ No
Comment: _____
Do you have problems with your teeth or dentures? ☐ YES ☐ No
Comment: _____
Do you have any problems with a cough? ☐ YES ☐ No
Comment: _____
Do you have chest pain, discomfort, or heaviness? ☐ YES ☐ No
Comment: _____
Do you have shortness of breath? ☐ YES ☐ No
Comment: _____
Do you have constipation, diarrhea, or change in bowel habits? ☐ YES ☐ No
Comment: _____
Do you have any problems with joint pain or stiffness? ☐ YES ☐ No
Comment: _____

Please list any symptoms or health concerns, which have not been addressed on this form.

_____

_____

_____

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