WALKER HEART INSTITUTE
Cardiovascular Clinic

PATIENT INFORMATION- PLEASE PRINT

SOC SEC #: _____-_____-_____ **MRN#:**_____

Name: _____
Last First Mid Initial

Home Phone: _____

Work Phone: _____**Ext:**_____

Address: _____ **Cell Phone:** _____

City: _____ **Date of Birth:** _____-____-_____ **Age:** _____yrs

State: _____ **Zip Code:** _____ **Employer:** _____

SEX: ☐ Male ☐ Female **Work Address:** _____

City: _____ **State:** ____ **Zip:** _____

MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced
☐ Partner ☐ Widowed Separated **Occupation:** _____

Email:_____@_____

PRIMARY CARE PHYSICIAN: _____

REFERRAL

Who referred you to our clinic? (***PLEASE CHECK BOX***)

☐ Washington Regional Medical Center
☐ Newspaper or Magazine
☐ Recommended by friend or family member
☐ Drove by Location of Clinic
☐ Community or Company Health Fair
☐ Treated by Physician in hospital
☐ Internet
☐ Phone Directory (Yellow pages)
☐ Referred by a Physician: _____
☐ Employer
☐ Insurance Plan Directory
☐Return Patient/ Not Applicable
☐ Other: _____

SPOUSE/PARENT INFORMATION

Spouse/Parent Name: _____ **Cell:** _____

Employer: _____ **Work:** _____ **Ext:** _____

Work Address: _____ **Spouse/Parent SEX:** ☐ Male ☐ Female

City: _____**State:** _____ **Zip:** _____ **Spouse/Parent Date of Birth:** _____/_____/_____

Occupation: _____ **Social Sec. #:** _____-_____-_____

EMERGENCY CONTACT INFORMATION

Emergency contact: _____ **Cell Phone:** _____

Address: _____ **Home Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Relationship to Patient:** _____

Patient Name: _____

PRIMARY INSURANCE

Patient's Relationship to *Main Policy Holder*: ☐ Myself ☐ Spouse ☐ Child ☐ OTHER: _____

Name of Insurance Company: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

ID# _____ Group # _____

Insurance Company's Phone Number: _____

Main Holder's Name: _____ **Main Holder's Date of Birth: _____/_____/_____**

Main Holder's Address: _____ **Main Holder's Soc Sec#: _____-_____-_____**

City: _____

State: _____ Zip: _____

SECONDARY INSURANCE

Patient's Relationship to *Main Policy Holder*: ☐ Myself ☐ Spouse ☐ Child ☐ OTHER: _____

Name of Insurance Company: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

ID# _____ Group # _____

Insurance Company's Phone Number: _____

Main Holder's Name: _____ **Main Holder's Date of Birth: _____/_____/_____**

Main Holder's Address: _____ **Main Holder's Soc Sec#: _____-_____-_____**

City: _____

State: _____ Zip: _____

GENERAL INFORMATION

Who is responsible for Payment?: ☐ **Myself** ☐ **Other:**_____ **(FILL OUT BELOW)**

Responsible Party Name: _____ **Responsible Party DOB:** _____/_____/_____

Relationship to Patient: ☐**Self** ☐**Spouse** ☐**Child** ☐**OTHER** **SS#**_____-_____-_____

Address: _____ **Phone#:**_____

Have you ever been seen as patient at one of our Washington Regional Medical System Clinics? ☐ **Yes** **No**

If Yes, When?:_____/_____/_____ **Where?:**_____

RELEASE OF INFORMATION **(spouse, children, parents, etc)**

Who may we discuss your information with? For example: Medical issues/care, results, billing, etc.

Name: _____ **Relation to Patient:** _____

Name: _____ **Relation to Patient:** _____

Name: _____ **Relation to Patient:** _____

Preferred Language: ☐**English** ☐**Spanish** ☐**Marshallese** ☐**Arabic** ☐**DECLINE** **OTHER:** _____

Race: ☐ **White** ☐**African American** ☐ **Asian** ☐ **Native Hawaiian/Other Pacific Islander**

☐ **Native American Indian/ Alaskan** ☐**Hispanic** ☐**Unknown** ☐ **DECLINE**

Ethnicity (Origin): ☐ **Not Hispanic or Latino** ☐ **Hispanic or Latino** ☐**Unknown** ☐**DECLINE**

Preferred Communication Method: ☐**Print** ☐**Save to Flash Drive** ☐**DECLINE**

Wellness Reminders: ☐**Mail** ☐**Cell Phone** ☐**Home phone** ☐**Work Phone** ☐**DECLINE**

PREFERRED PHARMACY: _____ LOCATION: _____

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 a copy of this authorization to be used in the place of the original. I consent for my photo to be taken. I understand that 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, attorneys, or insurance companies involved in my care. I give my permission for messages to be left on my answering machine or sent by email. I, the undersigned, authorize and consent to the rendering of medical care, including diagnostic procedures, and medical treatment by authorized members of Washington Regional Medical System or their designees, as may in their professional judgment be necessary for the above named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment. I have received a copy of the Notice of Privacy Practices of the clinic. I permit this facility to obtain my medication history electronically.

Patient Name:_____

X_____ **Date:** _____/_____/_____

Signature (Patient or Parent/Guardian if minor)

Cardiology Clinical History Form

First Name:_____ Middle:_____ Last:_____

SSN:_____-_____-_____ Date of Birth:_____/_____/_____ Gender: ❑ Male ❑ Female ❑ Other

Address:_____ City:_____ State:_____ Zip:_____

Home Phone: _____-_____-_____ Work Phone:( )_____-_____ Primary Physician: _____

Occupation: _____ Marital Status: _____ Number of Children: _____

Chief Complaint and Present Illness.

Reason for Consultation: ❑ Abn Echocadiogram ❑ ABN EKG ❑ Angina ❑ CAD ❑ Cardiac Arrythmia ❑ CHF ❑ HTN ❑ MI ❑ Pulmonary Edema ❑ Pulmonary Edema ❑ Stress Test ❑ Syncope ❑ Unstable Angina ❑ Physical Exam Other: _____

List All Symptoms: _____

If Symptom Includes Pain Check The One(s) That Best Describe: ❑ Aching ❑ Burning ❑ Continuous ❑ Cramping ❑ Deep ❑ Dull ❑ Gnawing ❑ Gradual ❑ Intermittent ❑ Mild ❑ Moderate ❑ Periodic ❑ Sharp ❑ Shifting ❑ Stabbing ❑ Sudden ❑ Superficial Other: _____

Risk Factors For CAD: ❑ CABG ❑ Elevated LDL ❑ F.H. of CVA ❑ F.H. of MI ❑ Hyperlipidemia ❑ Low HDL ❑ Obesity ❑ Sedentary Lifestyle ❑ Smoking

Duration: _____ **Location(s):** _____ **Historian:** _____

Date Symptom(s) Began:____ **Frequency of Symptom(s):** ❑ ____X Per Day ❑ ____X Per Week ❑ ____X Per Month ❑ ____X Per Year ❑ Constant ❑ Intermittent ❑ Occasional ❑ Rare ❑ Recurrent Other: _____

Intensity of Symptoms: ❑ Excruciating ❑ Mild ❑ Moderate ❑ Severe Other: _____

How Did Symptom(s) Start: _____

How Did Symptom(s) Progress: _____

What Brings It On: _____ **What Makes It Worse:** _____

What Relieves It: _____ **Associated Symptom(s):** _____

Antibiotic Usage: _____

Comments:

MEDICATIONS - List all medications you are currently taking. Include ALL medications even the Over The Counter ones.

Drug Name (Generic/Brand)	Dosage	Frequency	Status
			❑ Current ❑ Chronic ❑ DC'd
			❑ Current ❑ Chronic ❑ DC'd
			❑ Current ❑ Chronic ❑ DC'd
			❑ Current ❑ Chronic ❑ DC'd
			❑ Current ❑ Chronic ❑ DC'd

ALLERGIES - List all allergies including any medications that caused an allergic reaction.

List ALL Allergies	Allergic Reaction

Past Medical History - Please provide a complete history including all illnesses, injuries, hospitalizations and operations.

List ALL illnesses, Injuries & Operations	Date	Hospital	Treatment	Physician	Response
					Last Chest X-Ray:_____ ❑ Normal ❑ Abnormal Last EKG:_____

Family History - Please list all Blood Relatives with their current health status and any illnesses they have had or have.

List Blood Relatives	Health Status	Age If Living	Age At Death	Cause Of Death	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					

Mental Work: ❑ Omit ❑ Light ❑ Moderate ❑ Heavy Hours Per Day:_____

Physical Work: ❑ Omit ❑ Light ❑ Moderate ❑ Heavy Hours Per Day:_____

Exercise: ❑ Omit ❑ Light ❑ Moderate ❑ Heavy Hours Per Day:_____Types of Exercise:_____

Alcohol: ❑ Omit ❑ Never ❑ Beer(s)____Per Week ❑ Liquor____Per Week ❑ Wine____Per Week How Many Years:____

Smoking: ❑ Omit ❑ Never ❑ Current ❑ Previous Packs Per Day____ How Many Years____

Caffeine: ❑ Omit ❑ None Cups Per Day_____ How Many Years:_____ Other:_____

Aspirin: ❑ Omit ❑ None Quantity Per Day_____ How Many Years:_____ Other:_____

Nutritional Information: ❑ Low Sodium Diet ❑ Diabetic Diet ❑ Low Fat Diet ❑ Vegetarian Diet ❑ Low Cholesterol Diet ❑ Other:_____

Miscellaneous Drugs: ❑ Amphetamines ❑ Antacids ❑ Cocaine ❑ Diet Pills ❑ Laxatives ❑ Marijuana ❑ Nutrasweet ❑ Pain Pills ❑ Saccharin ❑ Sleeping Pills ❑ Vitamins ❑ Other:_____

First Name: _____ Middle: _____ Last Name: _____

Review of Symptoms - Check only the Ones you NOW have or have had RECENTLY.

General
- ❑ Weakness
- ❑ Fatigue
- ❑ Fever
- ❑ Chills
- ❑ Night Sweats
- ❑ Fainting
- ❑ None

Skin
- ❑ Color Changes
- ❑ Nail Changes
- ❑ Hair Changes
- ❑ Moles
- ❑ Rashes
- ❑ Itchy Skin
- ❑ Sores
- ❑ Dryness
- ❑ None

Head
- ❑ Headaches
- ❑ Injuries
- ❑ Bumps
- ❑ None

Eyes
- ❑ Blurred Vision
- ❑ Glaucoma
- ❑ Redness
- ❑ Itching
- ❑ Burning
- ❑ Swelling
- ❑ Pain
- ❑ Dryness
- ❑ Tearing
- ❑ None

Ears
- ❑ Hard of Hearing
- ❑ Deafness
- ❑ Ringing
- ❑ Discharge
- ❑ Earache
- ❑ Itching
- ❑ Loss of Balance
- ❑ Dizziness
- ❑ Room Spins
- ❑ None

Nose
- ❑ Decreased Smell
- ❑ Bleeding
- ❑ Pain
- ❑ Discharge
- ❑ Obstruction
- ❑ Post Nasal Drip
- ❑ Deviated Septum
- ❑ Runny Nose
- ❑ Sinus Congestion
- ❑ None

Mouth
- ❑ Bleeding Gums
- ❑ Sores
- ❑ Dental Problems
- ❑ Mouth Jaw Pain
- ❑ Bad Breath
- ❑ Loss of Taste
- ❑ Dryness
- ❑ Ulcers
- ❑ Blisters
- ❑ Bad Taste
- ❑ None

Throat
- ❑ Sore Throat
- ❑ Bad Tonsils
- ❑ Hoarseness
- ❑ Pain
- ❑ Hard To Swallow
- ❑ Recurrent Infections
- ❑ White Spots
- ❑ None

Neck
- ❑ Enlargement
- ❑ Stiffness
- ❑ Soreness
- ❑ Pain
- ❑ Lumps
- ❑ Masses
- ❑ None

Lungs
- ❑ Cough
- ❑ Phlegm
- ❑ Coughed Blood
- ❑ Shortness of Breath
- ❑ Wheezing
- ❑ Pain in Lungs
- ❑ Chest Congestion
- ❑ Inhalant Exposure
- ❑ None

Heart
- ❑ Murmur
- ❑ Palpitations
- ❑ Rapid Heartbeat
- ❑ Swollen Extremities
- ❑ Cold Extremities
- ❑ Tightness/Pressure
- ❑ Chest Pains
- ❑ Varicose Veins
- ❑ Blood Clots
- ❑ Blue Extremities
- ❑ None

Blood
- ❑ Broken Blood Vessels
- ❑ Anemia
- ❑ Easy Bruising
- ❑ Prolonged Bleeding
- ❑ Swollen Nodes
- ❑ Painful Nodes
- ❑ Red Dots/Spots
- ❑ None

Gastrointestinal
- ❑ Abdominal Pain
- ❑ Nausea
- ❑ Vomiting
- ❑ Abdominal Bloatedness
- ❑ Belching
- ❑ Heartburn
- ❑ Indigestion
- ❑ Irregular Bowels
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Hernias
- ❑ Poor Appetite
- ❑ Food Intolerance
- ❑ Bloody Stools
- ❑ Black Tarry Stools
- ❑ Excessive Appetite
- ❑ Rectal Bleeding
- ❑ None

Genitourinary
- ❑ Urgency
- ❑ Incontinence
- ❑ Straining
- ❑ Flank Pain
- ❑ Frequency
- ❑ Stones
- ❑ Burning
- ❑ Bed Wetting
- ❑ Bloody
- ❑ Small Stream
- ❑ Urethral Discharge
- ❑ Dribbling
- ❑ Cloudy Urine
- ❑ Unusual Color
- ❑ Urination at Night
- ❑ Hesitancy
- ❑ None

Musculoskeletal
- ❑ Pain
- ❑ Weakness
- ❑ Cramps
- ❑ Twitching
- ❑ Joint Stiffness
- ❑ Joint Pain
- ❑ Joint Swelling
- ❑ Joint Deformities
- ❑ Injuries
- ❑ Curvature of Spine
- ❑ Back Pain
- ❑ Hot Joint
- ❑ None

Neurological
- ❑ Seizures
- ❑ Vertigo
- ❑ Hand Trembling
- ❑ Loss of Sensation
- ❑ Incoordination
- ❑ Loss of Facial Expressions
- ❑ Weak Grip
- ❑ Paralysis
- ❑ Slurred Speech
- ❑ Tingling/Burning/Numbing
- ❑ Loss of Memory
- ❑ Lack of Concentration
- ❑ Disorientation
- ❑ Gait Shuffling
- ❑ None

Psychiatric
- ❑ Hyperventilation
- ❑ Insecurity
- ❑ Depression
- ❑ Insomnia
- ❑ Irritability
- ❑ Anxiousness/Stress
- ❑ Indecisiveness
- ❑ Timid/Shy/Bashful
- ❑ Hallucinations
- ❑ Alcohol Abuse
- ❑ Drug Use
- ❑ Suicidal Thoughts
- ❑ Worrying
- ❑ Obsessiveness
- ❑ Mania/Depression
- ❑ Multiple Personalities
- ❑ Sexual Difficulties
- ❑ Numbness
- ❑ Panic Attacks
- ❑ Compulsiveness
- ❑ None

Endocrine
- ❑ Weight Loss
- ❑ Weight Gain
- ❑ Hoarseness
- ❑ Heat Intolerance
- ❑ Cold Intolerance
- ❑ Breast Changes
- ❑ Loss of Hair
- ❑ Extreme Thirst
- ❑ Voice Changes
- ❑ Excessive Hair
- ❑ Hypoglycemia
- ❑ Diabetes
- ❑ None

Vital Signs

Height: _____ **Method:** ❑ Auricular ❑ Oral

Weight: _____ ❑ Axillary

Temp: _____ ❑ Forehead

Resp: _____ ❑ Rectal

	B.P.	Pulse	Extremity	Comment
Sitting:	_____	_____	_____	_____
Standing:	_____	_____	_____	_____
Supine:	_____	_____	_____	_____

Patient Consent for Use and Disclosure of Protected Health Information

Health Insurance Portability and Accountability Act (HIPAA)

Walker Heart Institute Cardiovascular Clinic

With my consent, Walker Heart Institute Cardiovascular Clinic may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Walker Heart Institute Cardiovascular Clinic's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Walker Heart Institute Cardiovascular Clinic reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Walker Heart Institute Cardiovascular Clinic and the Privacy Officer at 3211 N. North Hills Blvd., Suite 110, Fayetteville, AR 72703.

Walker Heart Institute Cardiovascular Clinic may call your home or other designated location and leave a message on an answering machine, voice mail, in person or with an individual that answers the phone in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, clinical care, laboratory and test results and any other items related to TPO. We may call your place of employment to give you information about your visit or send an email to the address you provide. We may discuss your care with your caregiver, the person who brings you to our office or to relatives who have shown an interest in your care. We may schedule appointments for follow-up visits, diagnostic tests, admits or hospital procedures while you or a designated person is at our check-out window or other designated areas within the clinic.

Walker Heart Institute Cardiovascular Clinic may mail to your home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, laboratory and test results and billing statements.

I have the right to request that Walker Heart Institute Cardiovascular Clinic restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Walker Heart Institute Cardiovascular Clinic's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Walker Heart Institute Cardiovascular Clinic may decline to provide treatment to me.

Signature of Patient or Legal Guardian	**Print Patient's Name**
Date	**Print Legal Guardian's Name**
Date of Birth	**Account Number**

WASHINGTON REGIONAL MEDICAL SYSTEM

NOTICE OF PRIVACY PRACTICES

YOUR INFORMATION

YOUR RIGHTS

OUR RESPONSIBILITIES

Effective Date: April 14, 2003

Revised: September 2013

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

My signature acknowledges that I have received the Notice of Privacy Practices.

_____

Signature

_____

Date of Birth

_____

Date

Washington Regional Medical System

www.wregional.com

Kristy Spruell, Corporate Compliance Officer
3215 N. North Hills Boulevard
Fayetteville, AR 72703
(479) 463-7641
Compliance@wregional.com

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting

Kristy Spruell, JD
Corporate Compliance Officer
3215 N. North Hills Boulevard
Fayetteville, AR 72703
(P) (479) 463-7641
(F) (479) 463-5977
Compliance@wregional.com

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• The Washington Regional Foundation may use information to notify you about fundraising campaigns or other charitable events. You have the right to opt out of fundraising communications and may do so by calling (479) 463-7641 or emailing Compliance@wregional.com.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We may contact you for quality assurance and reporting purposes using auto-dialed and/or artificial or prerecorded message calls or text to your cellular telephone and/or to the telephone number you provided during the registration process. We may also contact you for these purposes using the email address you provided during the registration process. You may opt out of these calls and emails by calling (479) 463-7641 or emailing Compliance@wregional.com.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

May 25, 2018

This Notice of Privacy Practices applies to the following organizations.

Washington Regional Medical Center, Washington Regional Medical System, and each of their respective wholly owned affiliates and subsidiaries.

Kristy Spruell, Corporate Compliance Officer
Compliance@wregional.com
(479) 463-7641

KEEP IN TOUCH

through the

Patient Portal

- ☺ **Help us be efficient in communicating with you**
- ☺ **Request medication refills**
- ☺ **Request an appointment**
- ☺ **Ask a question**
- ☺ **Inform us of changes in your cardiac health**
- ☺ **Keep your blood pressure log**
- ☺ **See your lab results**

Request this card and activate your account today.

Creating an account is easy and free:

Step 1 Go to **www.wrhealthlink.com**

Step 2 Click on the "Create an Account" Tab. **Enter your PIN** and last name to identify yourself.

Step 3 Provide current email address, password and secret question answers. Click *Register.*

Step 4 Once you've finished registering, you'll receive a verification email. Click the link in that email to complete the registration process.

You now have an account!

Your PIN:

To find your clinical information, go to

My Health Record

and select DOCUMENTS. Select the date of your visit to view your record.

For assistance in using YOUR patient portal, please call 1.USREGIONAL (1.877.344.6625).

WR | HealthLink

by Washington Regional

Thank you from our hearts