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

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

HIPAA Privacy Notice

Effective Date: April 14, 2003
Revised: June 2015

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.

WASHINGTON REGIONAL MEDICAL SYSTEM RESPONSIBILITIES

Washington Regional is committed to protecting the confidentiality of your health information. The System creates a record of the care and services you receive at our facilities. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will inform you as to the ways we may use and disclose information about you and your health ("health information"). This notice also describes your rights and certain obligations we have regarding the use and disclosure of your health information.

This notice applies to all of the records of your care generated or maintained by the System, whether made by Washington Regional personnel or your doctor.

The Health Insurance Portability and Accountability Act ("HIPAA") requires that Washington Regional maintain the privacy of your health information and provide you this notice as to our legal duties and privacy practices with respect to health information. When Washington Regional uses or discloses health information, it is required to abide by the terms of this notice. Washington Regional reserves the right to change our privacy practices and this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. Our current notice may be accessed on the Washington Regional web page at http://www.wregional.com. Revised notices will also be posted in facility patient waiting areas. You may also receive current copies of our notice by sending a written request to the System privacy officer.

Washington Regional is required by law to let you know promptly if a breach occurs that may have compromised the privacy of security of your health information.

If you have any questions about this notice, contact the Washington Regional Privacy Officer at 479-463-7640, or by writing to Washington Regional Privacy Officer, 3215 N. North Hills Blvd., Fayetteville, AR 72703.

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.

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 health information
- Most sharing of psychotherapy notes

In the case of fundraising:

- Washington Regional may contact you for fundraising efforts to help sustain our mission, but **you can tell us not to contact you again**. The Washington Regional Medical Foundation will provide you with the necessary information to communicate your preference to be removed from fundraising lists.
- Directories. Washington Regional may maintain a directory of patients that includes your name and location within the facility, your religious designation, and information about your condition in general terms that will not communicate specific health information about you. Except for your religion, Washington Regional may disclose this information to any person who asks for you by name. Washington Regional may disclose all directory information to members of the clergy.
- Notifications. Washington Regional may disclose to your relatives or close personal friends any health information that is directly related to that person's involvement in the provision of, or payment for, your care. Washington Regional may also use and disclose your health information for the purpose of locating and notifying your relatives or close personal friends of your location and general condition or death, and to Organizations that are involved in those tasks during disaster situations.
- Except as described in this Notice, disclosures of your health information will be made only with your written authorization. You may revoke your authorization at any time, in writing, unless we have taken action in reliance upon your prior authorization, or if you signed the authorization as a condition of obtaining insurance coverage.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION
The following sections describe the circumstances for which Washington Regional may use and disclose your health information without obtaining prior authorization and without offering you an opportunity to object.

- Treatment. Washington Regional may use and disclose your health information to provide you with medical treatment and services. Washington Regional may disclose health information about you to doctors, nurses, technicians, students, or other health care personnel who are involved in your care. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the hospital's dietitian if you have diabetes so that we can arrange for appropriate meals. Washington Regional may also share your health information with other Washington Regional personnel or non-Washington Regional providers, agencies, or facilities in order to coordinate the services you may need, such as prescriptions, lab work and x-rays. Washington Regional may also disclose health information to persons outside Washington Regional who may be involved in your continuing medical care after you leave Washington Regional, such as another hospital, a nursing home, a home health provider, a rehabilitation hospital, community agencies and family members.
- Payment. Your health information will be used or disclosed, as necessary, to secure payment for your health care services. Washington Regional may use your health information so that the treatment and services you receive at Washington Regional or from other entities, such as an ambulance company, may be billed and payment collected from you, an insurance company or a third party. For example, we may share your health information with your health insurance company and provide your diagnosis and treatment in order to assist the insurer in processing the claim for the healthcare services provided to you.
- Health Care Operations. Washington Regional may use and/or disclose your information for the purposes of our day-to-day operations and functions. We may also disclose your information to another covered entity to allow it to perform its day-to-day functions, but only to the extent that we both have a relationship with you. For example, we may compile your health information, along with that of other patients, in order to allow a team of our health care professionals to review that information and make suggestions concerning how to improve the quality of care provided at this facility. Also, we may contact you as part of our efforts to raise funds for the Organization. All fundraising communications will include information about how you may opt out of future fundraising communications.

  Washington Regional may also use and/or disclose your health information:

- When required by law;
- For public health purposes such as vital statistics and preventing or controlling disease;
- To disclose information about victims of abuse, neglect or domestic violence;
- For health oversight activities, such as audits or civil, administrative or criminal investigations;
- For judicial or administrative proceedings;
- For law enforcement purposes;
- To assist coroners, medical examiners or funeral directors with their official duties;
- To facilitate organ, eye or tissue donation;
- For certain research projects that have been evaluated and approved through a research approval process that takes into account patients' need for privacy.
- To avert a serious threat to public or health safety;
- Washington Regional Medical Center and the independent members of its Medical and Allied Health Staffs participate in an organized health care arrangement, as recognized by law, so that they may share your health information in the course of providing your treatment, performing peer review, quality improvement activities, medical education, and conducting the payment and health care operations associated with your care at any Washington Regional Medical System facility.
- For specialized governmental functions, such as military, national security, criminal corrections, or public benefit purposes; and
- For workers' compensation purposes, as permitted by law.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Your health information is the property of Washington Regional. You have the following rights, however, regarding health information we maintain about you:

- Right to Inspect and Copy. With certain exceptions, you have the right to inspect and copy your health information for as long as we maintain that information.

  To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to the appropriate Medical Record Department of the Washington Regional entity that maintains your health information. A list of all Washington Regional record departments and their addresses is set forth at the end of this Notice. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. You may request an electronic or paper copy of your record. The copy or summary of your health information will be provided to you, usually within 30 days of your request. We may charge a reasonable cost based fee.
- Right to Request an Amendment or Addendum. If you believe that health information Washington Regional has about you is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record). You have the right to request an amendment or addendum for as long as the information is kept by or for Washington Regional.

  To request an amendment, your request must be made in writing and submitted to the medical record department of the Washington Regional entity that maintains your information at the appropriate address set forth at the end of this Notice. In addition, you must provide a reason that supports your request.

  Washington Regional may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - Was not created by Washington Regional medical staff or employees, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the health information kept by or for Washington Regional;
  - Is not part of the information which you would be permitted to inspect and copy; or
  - Is accurate and complete.

- Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of your health information. This right does not apply to disclosures made for purposes of treatment, payment, and health care operations or disclosures that are subject to certain restrictions, exceptions, and limitations imposed by law.

  To request an accounting of disclosures, you must submit your request in writing to Washington Regional Privacy Officer, 3215 N. North Hills Blvd., Fayetteville, AR 72703. Your request must state a time period that may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. Washington Regional will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

  We will ordinarily respond to your request for an accounting within 60 days. If we require additional time to prepare the accounting you have requested, we will notify you in writing about the reason for the delay and the date you can expect to receive the accounting.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery performed at Washington Regional.

  We are not required to agree to your request. If we do agree, our agreement must be in writing and we will comply with your request unless the information is needed to provide you emergency treatment.

  To request a restriction, you must make your request in writing to the Washington Regional Privacy Officer, 3215 N. North Hills Blvd., Fayetteville, AR 72703. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a more confidential way by requesting that we communicate with you by alternative means or at alternative locations. For example, you can ask that we only contact you at home or by mail, or send to a different address or call an office phone.

  To request more confidential communications, please make your request in writing to Privacy Officer, 3215 N. North Hills Blvd., Fayetteville, AR 72703. We will not ask you the reason for your request, and we will try to accommodate reasonable requests. Please specify in your request how or where you wish to be contacted, and how payment for your health care will be handled if we communicate with you through the requested alternative method or location.
- Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

You may obtain a copy of this notice at our website, http://www.wregional.com or by writing Privacy Officer, 3215 N. North Hills Blvd., Fayetteville, AR 72703, telephone number 479-463-7640.

- Ask us to Limit What We 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 or our operations. 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.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with Washington Regional or with the Secretary of the Department of Health and Human Services. To file a written complaint with Washington Regional, contact Privacy Officer, 3215 N. North Hills Blvd., Fayetteville, AR 72703, telephone number 479-463-7640.

You will not be penalized for filing a complaint.

File a Complaint if you feel your rights are violated.

- You can complain if you feel we have violated your rights by contacting us using the following information:
- Contact the Washington Regional Medical System Privacy Officer at 479-463-1000, or by letter addressed to Privacy Officer at 3215 N. North Hills Blvd., Fayetteville, AR 72703, or by e-mail to compliance@wregional.com.
- You can file a complaint with the U.S. Department of Health and Human Services Officer for Civil Rights by letter addressed to U.S. Department of Health and Human Services Office for Civil Rights, 200 Independence Ave., S.W., Washington, D.C. 20201, or by calling 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

OTHER USES OF HEALTH INFORMATION.
Other uses and disclosures of health information not covered by this notice or the laws that apply to Washington Regional will be made only with your written authorization, giving us permission for such uses or disclosures. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time, by contacting Privacy Officer, 3215 N. North Hills Blvd., Fayetteville, AR 72703. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. Washington Regional is unable to take back any disclosures already made with your permission, and we will retain our records of the care that we provided to you as required by law.

When this Notice refers to "the System", it is referring to Washington Regional Medical System (Washington Regional) and certain of its affiliated entities, including, but not limited to: Washington Regional Medical Center, Washington Regional Home Health, Washington Regional Hospice, Fayetteville City Hospital, Washington Regional Family Clinic Fayetteville, HerHealth by Washington Regional, JPA Clinic, Washington Regional Diagnostic Clinic, Washington Regional Family Clinic Eureka Springs, Washington Regional Family Clinic Springdale, Northwest Arkansas Neuroscience Institute, WR Ozark Urology, Washington Regional Clinic for Senior Health, Washington Regional Memory Clinic, Walker Heart Institute Cardiovascular Clinic, Walker Heart Institute Harrison Cardiology, and Washington Regional Wound Care Clinic together with all Washington Regional employees, staff, volunteers, medical, nursing and other health care students, persons or entities performing services for Washington Regional under agreements containing privacy protections or to which disclosure of health information is permitted by law. For certain activities,

Washington Regional Medical Record Departments:

Washington Regional Family Clinic Eureka Springs
Attn: Medical Records
146 A Passion Play Road
Eureka Springs, AR 72632

HerHealth
Attn: Medical Records
3215 N. North Hills Blvd, Suite B
Fayetteville, AR 72703

Washington Regional – Home Health
Attn: Director
88 Colt Square
Fayetteville, AR 72703

Washington Regional Diagnostic Clinic
Attn: Medical Records
3000 Northwest A
Bentonville, AR 72712

Washington Regional – Hospice
Attn: Director
34 Colt Square
Fayetteville, AR 72703

Washington Regional Family Clinic Fayetteville
Attn: Medical Records
3053 N. College Ave.
Fayetteville, AR 72703
Washington Regional Medical Center
Attn: Medical Records
3215 N. North Hills Blvd.
Fayetteville, AR 72703

Hidden Springs Diagnostic Clinic
Attn: Medical Records
3000 N.W. A Street
Bentonville, AR 72712

Northwest Arkansas Neuroscience Institute
Attn: Medical Records
3336 N. Futrall Drive
Fayetteville, AR 72703

Washington Regional Family Clinic Springdale
Attn: Medical Records
813 Founders Park Drive
Springdale, AR 72762

Washington Regional Senior Clinic
Attn: Medical Records
12 East Appleby Road
Fayetteville, AR 72703

WR Ozark Urology
Attn: Medical Records
3211 N. North Hills Boulevard
Fayetteville, AR 72703

Walker Heart Institute Cardiovascular Clinic
Attn: Medical Records
3211 N. North Hills Boulevard
Fayetteville, AR 72703

Walker Heart Institute Harrison Cardiology
Attn: Medical Records
702 N. Spring Street
Harrison, AR 72601

Washington Regional Family Clinic – Farmington
Attn: Medical Records
199 East Main Street
Farmington, AR 72730

Washington Regional Rheumatology
Attn: Medical Records
3336 N. Futrall
Fayetteville, AR 72703

Harrison Family Practice Clinic – Washington Regional
Attn: Medical Records
715 W. Sherman Ave., Suite G
Harrison, AR 72601

Washington Regional Family Clinic – East Springdale
Attn: Medical Records
813 Founders Park Drive
Springdale, AR 72764

Crossroads Medical Clinic – Washington Regional
Attn: Medical Records
1420 Hwy 62/65
Harrison, AR 72601

Washington Regional Nephrology
Attn: Medical Records
813 Founders Park
Springdale, AR 72762

Renal Specialists of Northwest Arkansas
Attn: Medical Records
813 Founders Park
Springdale, AR 72762

Shiloh Clinic Washington Regional
513 N. Shiloh Street
Springdale, AR 72762