Welcome to Washington Regional West Washington County Clinic!

Thank you for choosing us for your care! Please read the important information below to help your visit go smoothly.

What You Need to Do

- Please complete and return the attached forms.
- You can send them back by mail, email, or fax using the contact information below.
- Once we receive your forms, we will call you to schedule your appointment.

Washington Regional
West Washington County Clinic
(located on the Lincoln Square)
106 W. Park St.
PO Box 800
Lincoln, AR 72744
Fax: 479.404.4397

Washington Regional
West Washington County Clinic
(located at the Lincoln Middle School)
201 E. School St.
Lincoln, AR 72744

Email: wwcc@wregional.com

Important Information About Our Services

Our clinicians do not treat chronic pain conditions or prescribe certain psychiatric medications, including but not limited to controlled substances for pain, or medications primarily used to treat conditions such as ADHD, bipolar disorder, or anxiety without sufficient testing.

Before Your Appointment

- If you have insurance, please bring your insurance card and be ready to pay any copayment at the time of your visit.
- If you do not have insurance, payment is due at the time of your appointment.

Please Let Us Know If...

- **You have Medicaid:** Call Connect Care at 1.800.275.1131 to get assigned to our clinic.
- **You need to reschedule:** Call us as soon as possible.
- **You need immunizations for you or your child:** Call ahead, as some vaccines are in limited supply.

About Missed Appointments

We know that life happens. If you miss an appointment, please call us as soon as possible. Missing appointments:

- Can delay your care and the care of other patients
- May require extra time to get you back on the schedule

After 3 missed appointments (no-shows), we may need to end our care relationship with you.

Questions?

We're here to help!
Call us at 479.824.3196. We look forward to caring for you and your family.

Please note: For your health and the health of others, please call at least 24 hours in advance if you need to cancel or reschedule.

Thank you for being part of our clinic family!

NEW PATIENT INFORMATION FORM

Please complete this form as accurately as possible.

PATIENT INFORMATION

Full Name: _____Date of Birth: _____ Age: _____

Sex: ☐ Male ☐ Female ☐ Other Pronouns: _____ Social Security #: _____

Home Phone Number: _____ Cell Phone:_____

Mailing Address: _____City: _____

State:_____ Zip Code: _____ E-mail:_____

Who is responsible for payment: ☐ Myself ☐ Other: _____

Guarantor Name: _____ Relationship: _____

Guarantor's Address: _____

Language: ☐ English ☐ Spanish ☐ Other : _____ ☐ Decline

Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Native Hawaiian/Other Pacific Islander

☐ Native American Indian/Alaskan ☐ Other _____ ☐ Decline

Ethnicity (Origin): ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown ☐ Decline

Emergency Contact: _____Relationship: _____ Phone: _____

Preferred Pharmacy: _____Pharmacy Phone/Location: _____

Mail Order Pharmacy: _____ Pharmacy Phone/Location: _____

PATIENT EMPLOYER

Employment Status: ☐ Full Time ☐ Part-time ☐ Unemployed ☐ Student

☐ Retired, date of retirement ____/____/_____ Are you a Veteran: ☐ No ☐ Yes

Employer Name: _____Employer Address: _____

Employer Phone: _____ Occupation: _____

SPOUSE / PARENT INFORMATION

Spouse/Parent Name: _____ Date of Birth: ____/____/_____

Cell: _____ Work Phone: _____

Work Address: _____ Occupation: _____

HIPAA NOTICE OF PRIVACY

Patient Name: _____ Date of Birth: _____

Your Consent to Use and Share Your Health Information

We respect your privacy. This form explains how your health information may be used or shared and asks for your permission to do so.

1. What Information We Use We may use or share:

- Your name, address, and contact details
- Your medical history, test results, and treatment plans • Insurance and billing information

2. Why We Use or Share It We may use your information to:

- Treat you and coordinate your care
- Bill your insurance or other payers
- Improve our services or meet legal obligations

3. Who Can See Your Information

Your information may be shared with:

- Doctors, nurses, and medical staff treating you
- Insurance companies for payment
- People you name (like family or caregivers)

_____

_____

_____

4. Your Rights

- You can ask to see or get a copy of your health records
- You can ask us to correct something in your records
- You can take back your consent at any time (in writing)

Guardian Signature: _____ **Date:** _____

Patient Signature: _____ **Date:** _____

TERMS AND CONDITONS OF SERVICE:
GENERAL CONSENT AND FINANCIAL AGREEMENT

Washington Regional – Who we are; Purpose of this Agreement. Thank you for seeking medical care from Washington Regional Medical System, an integrated health system made up of various entities, including (but not necessarily limited to) the general hospital known as Washington Regional Medical Center ("WRMC") and each of the respective hospital outpatient departments, specialty providers, and physician clinics that are specifically identified in the Washington Regional Notice of Privacy Practices, which all will be collectively referred to herein as "Washington Regional." This Consent to Medical Care Agreement authorizes Washington Regional to provide you medical care, share your health information and seek payment for the services provided. In this document, "Patient" means the person receiving treatment. "Patient Representative" means any person acting on behalf of the Patient and signing as the Patient's lawful representative. Use of the word "I", "you", "your" or "me" may in context include both the Patient and the Patient Representative. With respect to financial obligations "I", "you" or "me" may also, depending on the context, mean the "Guarantor", who is the financial guarantor of the Patient's account.

Acknowledgment of Notice of Privacy Practices. The Health Insurance Portability and Accountability Act of 1996 ("HIPPA") is a federal law that protects the privacy and security of your health information anywhere in the United States. The Washington Regional Notice of Privacy Practices is a complete description of your HIPAA privacy rights as a patient of Washington Regional and further describes the ways in which HIPAA permits Washington Regional to use and disclose your healthcare information for its treatment, payment, healthcare operations and other prescribed and permitted uses and disclosures. By signing below, you acknowledge that you have received the Washington Regional Notice of Privacy Practices.

Acknowledgment of Patient Information Guide. If I am seeking care at WRMC, I acknowledge that I have been provided a copy of the Washington Regional Medical Center Patient Information Guide. The Patient Information Guide provides a detailed statement of your rights and responsibilities as a patient at WRMC.

Consent for Diagnosis, Care and Treatment. I consent to and authorize Washington Regional and each of the physicians and other health care providers who may be involved in my care at Washington Regional to provide such diagnosis, care and treatment considered necessary for the condition for which I am seeking care or as may otherwise be advisable for my wellbeing. I consent to the procedures which may be performed during hospitalization or during an outpatient episode of care, including, but not limited to, emergency treatment or services, and which may include laboratory procedures, administration of blood and blood products, x-ray examination, diagnostic procedures, medical, nursing or surgical treatment or procedures, anesthesia, or hospital services as ordered by a physician, allied health professional or other licensed independent practitioner. To facilitate my diagnosis, care and treatment, I further consent to evaluation and examination by a physician who may be physically distant from me via telemedicine technologies, including but not limited to two-way video, digital images, and other telemedicine technology as determined by Washington Regional and as permitted by applicable law. I understand that the practice of medicine (including surgery) is not an exact science and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, diagnosis, test, treatment, or surgery performed at Washington Regional. If I am pregnant, I understand that all the provisions in this Terms and Conditions of Service: General Consent and Financial Agreement apply to my newborn child/children for their medical care and treatment.

I further consent to treatment and care by physicians and allied health professionals who are not employees or agents of Washington Regional but are authorized by Washington Regional through the grant of clinical privileges to provide treatment and care to me as a patient of Washington Regional. Washington Regional has entered into agreements with academic medical centers, independent physician groups, and allied health professional groups to provide specialized services such as anesthesiology, pathology, perfusionist, telemedicine, and intensivist services. The members of these institutions or groups are not employees of Washington Regional but have clinical privileges to practice at Washington Regional. I agree not to hold Washington Regional responsible for the medical care of any non-employed physicians or allied health professionals with clinical privileges at Washington Regional and release Washington Regional from any liability for any injury or harm caused to me by any non-employed physician or allied health professional with clinical privileges at Washington Regional.

Teaching and Research Activities. I understand that the mission of Washington Regional includes serving as a teaching hospital and clinical training site. I understand that residents, interns, medical students, students of ancillary health care professions (e.g., nursing, radiological technicians, physician assistants), and other trainees may observe, examine, treat, and participate at the request and under the supervision of the attending physician in my care as part of Washington Regional's medical education programs. I consent to allowing students as part of their training in health care education to participate in the delivery of my medical care and treatment or be observers while I receive medical care and treatment at Washington Regional, and that these students will be supervised by qualified physicians and/or Washington Regional staff. I understand that the mission of Washington Regional includes the conduct of medical research and the advancement of medical science. I also understand that the Washington Regional Institutional Review Board approves research projects conducted by physicians, nurses, medical, nursing and allied health students, and other Washington Regional staff who are credentialed or otherwise authorized by Washington Regional to conduct such research in accordance with state and federal law. I understand that I may be contacted and asked to participate in research studies but that I am under no obligation to do so. My decision whether to participate or not will not affect my ability to obtain medical care.

Personal Valuables. I acknowledge that Washington Regional requests that patients not bring valuable items into its facilities. I understand that my personal property is my responsibility and that Washington Regional is not responsible for the loss, destruction or theft of my personal property. I have been advised to send all personal valuables home in the event I am admitted to the WRMC hospital facility. Washington Regional shall not be liable for the loss of or damage to any personal property, including, but not limited to, money, purses, glasses, hearing aids, dentures, jewelry, cell phones, electronic devices, or other articles of unusual value, unless deposited for safekeeping in the fireproof safe maintained by WRMC and evidenced by a documentary receipt issued to you by WRMC.

Patient Recording Prohibited. I understand that I am not allowed to take pictures or make video or audio recordings of my care, other patients, visitors, Washington Regional employees, physicians or students in Washington Regional facilities.

AGREEMENT TO PAY FOR SERVICES

Financial Agreement. In consideration of the services to be rendered to the patient, I individually promise to pay the patient's account at the rates established in the hospital's price list (known as the "Charge Master") as the same are in effect as of the date the charge is processed for the service provided, which rates are hereby expressly incorporated by reference as the price term of this agreement. Some special items will be priced separately if there is no price listed on the Charge Master.

Estimates. An estimate of the anticipated charges for services to be provided the Patient is available upon request. Estimates may vary significantly from the final charges based on a variety of factors, including, but not limited to, the course of treatment, intensity of care, physician practices, and the necessity of providing additional items or services. Out-of-pocket estimates may also vary due to any change of insurance information. Washington Regional will not be responsible for any inaccurate or outdated information available or presented at the time an estimate is given.

Professional services provided by independent contractors are not included within or part of the Washington Regional bill. These services will be billed to the patient separately by the service provider. I understand that physicians or other health care providers may be called upon to provide care or services to me or on my behalf, but that I may not see, or be examined by, all physicians or health care professionals participating in my care. For example, I may not see physicians or allied health professionals who provide pathology, radiology, anesthesiology, or neuromonitoring services for my benefit. I understand that, in most instances, there will be a separate charge for professional services rendered by physicians to me or on my behalf, and that I will receive a bill for these professional services that is separate from the bill for hospital services.

WRMC will provide a medical screening examination to any individual who comes to the emergency department to determine if there is an emergency medical condition without regard to a patient's ability to pay. If an emergency medical condition is determined to exist, WRMC will provide stabilizing treatment within its capability and capacity or arrange for an appropriate transfer, all in accordance with applicable law. However, the patient understands that if the patient does

not qualify for financial assistance under the WRMS Financial Assistance Policy, the patient is not relieved of his or her obligation to pay for these services.

If supplies and services are provided to a patient who has coverage through a governmental health insurance program or certain private health insurance plans with whom Washington Regional has contractual agreements, Washington Regional may accept a discounted payment for those supplies and services. In this event any payment required from the patient will be determined by the terms of the applicable governmental program or private health insurance agreement. If the patient is uninsured and not covered by a governmental health care program, the patient may be eligible to have his or her account discounted or forgiven in accordance with the terms of applicable Washington Regional uninsured discount policies or the Washington Regional Financial Assistance and Collection Policy. I understand that I can find additional information about how to apply for such assistance in the Patient Information Guide under the "Financial Assistance" heading.

I also understand that Washington Regional, as a courtesy to me, may bill my insurance company, health benefit plan, or other non-governmental payer concerning the services and goods provided by Washington Regional to me, but that Washington Regional may not be obligated to do so. Except as prohibited by law or by written agreement of Washington Regional, I agree to pay for any charges not covered and covered charges not paid in full by any applicable insurance and/or health benefit plan including charges payable as co-insurance, deductibles, and non-covered benefits due to policy and/or plan limitations, exclusions, and/or failure to comply with insurance and/or plan requirements. I further agree that any credit balance resulting from payment of insurance or other sources may be applied by Washington Regional to any other account owed to Washington Regional by me.

Assignment of Benefits. In consideration for the medical services provided to me by Washington Regional, and as further consideration for Washington Regional's provision of those medical services to me without requiring full payment at the conclusion of service, I hereby make the following agreements concerning assignment of benefits to which I may be entitled under the terms of any applicable insurance plan or policy, including without limitation, health insurance, group health plan, employer-sponsored medical benefit plan, third-party liability insurance, accident medical payments/PIP/bodily injury or uninsured/underinsured motorist policy(ies).

I hereby **irrevocably assign and convey** to Washington Regional, as my designated authorized representative, the right to receive and pursue payment of all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for medical services, treatments, procedures, therapies, and/or medications rendered or provided by Washington Regional for the date(s) of service noted herein, and future treatment and services, regardless of its managed care network participation status. This Assignment of Benefits shall apply to all insurance coverage, including but not limited to, the Centers for Medicare and Medicaid Services, its intermediaries, carriers or administrative contractors, State Medicaid programs, or any other governmental or commercial insurance. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Washington Regional to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to Washington Regional any and all plan documents, summary benefit description, insurance policy(ies), and/or settlement information upon written request from Washington Regional or its attorneys in order to claim such medical benefits.

I further **irrevocably assign and convey** to Washington Regional any legal or administrative claim or cause of action arising under any group health plan, employer-sponsored medical benefit plan, health insurance, or third-party liability insurance concerning medical expenses incurred as a result of the medical services, treatments, procedures, therapies, and/or medications I received from Washington Regional (including any right to pursue those legal or administrative claims or choses in action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims. In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also **irrevocably assign and convey** to Washington Regional all right, title, and interest in benefits payable out of any third party liability claim or action that I have against any other person, entity, or insurance company, or out of recovery under the uninsured motorist provisions or the medical payment provisions of any automobile insurance policy(ies) or any other insurance policy under which I may be entitled to recover. Provided, however, that any such assignment shall not exceed the amount charged for the services provided.

In furtherance of the foregoing, I hereby **irrevocably appoint** Washington Regional as my authorized representative to pursue any claims, penalties, and administrative and/or legal remedies on my behalf for collection against any responsible payer, employer-sponsored medical benefit plans, third-party liability carrier, or any other responsible third-party for any and all benefits due me for the payment of charges associated with my medical care and treatment. This assignment shall not be construed as an obligation of Washington Regional to pursue any such right of recovery. I acknowledge and understand that I maintain my right of recovery against my insurer or health benefit plan and the foregoing assignment does not divest me of such right.

I agree to take all actions necessary to assist Washington Regional in collecting payment from any responsible payer, employer sponsored medical benefit plans, third-party liability carriers, or other responsible parties should Washington Regional elect to collect such payment(s), including allowing Washington Regional to bring suit against such insurance carriers or responsible third parties. If I receive payment directly from any source for the medical charges associated with my treatment at Washington Regional, I acknowledge that it is my duty and responsibility to immediately pay any such payment to Washington Regional.

I fully understand that my financial obligation to Washington Regional is not contingent upon any settlement, claim, judgment or verdict which may be recovered, and that I am and remain fully responsible for payment of all charges incurred for medical treatment and care provided me by Washington Regional. Any delay in attempt to recover payment or exercise any right to pursue any source of payment shall not be deemed a waiver of such right to pursue payment directly.

Medicare/Medicaid/Insurance Certification, Assignment & Payment Request. I have been informed that Medicare will only pay for services that it determines to be reasonable and necessary under Section 1862(a)(1) of the Social Security Act. I certify that the information given by me or by my authorized representative in applying for payment for my health care under the Medicare or Medicaid programs is correct. I request that payment of the authorized benefits be made to the appropriate Washington Regional affiliate on my behalf.

Third-Party Collection. I acknowledge and understand that if I fail to pay the charges incurred by me for the medical care and treatment provided by Washington Regional, Washington Regional will undertake collection activities in accordance with the terms of the Washington Regional Financial Assistance and Collection Policy, a copy of which can be obtained at www.wregional.com/main/financial-assistance, which activities may include the assignment of my past-due account to a third-party collection agency and the initiation of Extraordinary Collection Activities as defined in the Financial Assistance and Collection Policy. I further acknowledge and agree that in the event Washington Regional or a third-party collection agency to whom Washington Regional assigns my outstanding account(s) initiates collection efforts to recover any amounts owed by me, then, in addition to the outstanding amount owed and incurred by me for medical care and treatment, I will pay, to the extent permitted by law, any and all costs incurred by Washington Regional or its assignee in pursuing collection, including court costs, pre-judgment and post-judgment interest, and reasonable attorney's fees. I acknowledge, consent and agree that the federal or state courts situated in Washington County, Arkansas shall serve as the proper venue for any legal proceeding filed to collect any amounts owed by me for medical care and treatment rendered by Washington Regional.

Consent to Telephone Calls for Financial Communications. I agree that, in order for Washington Regional, or Washington Regional's authorized third-party collection agency, to service my account or to collect any amounts I may owe, I expressly agree and consent that Washington Regional or its authorized agents may contact me by telephone or text message at any telephone number I have provided or that is otherwise associated with my account and that such communication may result in my incurring fees for the call or text message. I understand, acknowledge and agree that Washington Regional's authorized third-party collection agencies may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that Washington Regional and Washington Regional's authorized third-party collection agencies may contact me using e-mail at any e-mail address I provide to Washington Regional or that is otherwise associated with my account.

Presentation of Consent to Medical Care Agreement. I acknowledge that I will be presented with this Terms and Conditions of Service: General Consent and Financial Agreement (a) for every visit I make to WRMC, whether an emergency department encounter, outpatient hospital admission, or inpatient hospital admission, and (b) once every twelve months where I visit a Washington Regional specialty clinic or physician clinic.

PATIENT CERTIFICATION:

I HAVE READ, UNDERSTOOD AND FULLY AGREE TO each of the above statements and sign below as my free and voluntary act.

I FURTHER ACKNOLWEDGE that I have been provided with the Washington Regional Patient Information Guide and the Washington Regional Notice of Privacy Practices.

X _____ Date:_____ Relationship to Patient: _____

Patient or Patient Representative Signature

X _____ Date: _____

Signature of Witness

FINANCIAL RESPONSIBILITY AGREEMENT BY GUARANTOR:

I agree to accept financial responsibility for the medical services rendered to the patient and agree to and accept the terms of the Financial Agreement, Assignment of Benefits, Third-Party Collection, and Consent to Telephone Calls for Financial Communications paragraphs set forth above.

X _____ Date: _____

Guarantor

X _____ Date: _____

Signature of Witness

Patient Name: _____DOB: _____Date: _____

REASON FOR VISIT

_____

_____

_____

REVIEW OF SYSTEMS

Are you currently experiencing any of the following?

☐ Fever
☐ Weight Loss
☐ Chest Pain
☐ Shortness of Breath
☐ Cough
☐ Abdominal Pain
☐ Nausea/Vomiting
☐ Diarrhea
☐ Constipation
☐ Headaches
☐ Dizziness
☐ Anxiety
☐ Depression
☐ Rash
☐ Joint Pain
☐ Swelling
☐ Urinary issues
☐ Other: _____

Comments: _____

MEDICAL HISTORY

Current Medical Problems (Check all that apply)

☐ Anxiety
☐ Arthritis
☐ Asthma/COPD
☐ Cancer
☐ Depression
☐ Diabetes
☐ GERD/Reflux
☐ Heart Disease
☐ Heart Rhythm Disorder
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney Disease
☐ Migraines
☐ Osteoporosis
☐ Thyroid Disease
☐ Sleep Apnea
☐ Other: _____
_____

SURGICAL HISTORY ☐ No Surgical History

Surgery/Procedure	Year

Patient Name: _____ DOB: _____ Date: _____

FAMILY HISTORY (Check any family history of the following)

Family Member	Age	Living	Deceased	Health Problems
Father				
Mother				
Brother(s)				
Sister(s)				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				

ALLERGIES ☐ No Known Allergies

Medication/Food/Environmental Allergy	Reaction

CURRENT MEDICATIONS ☐ No Current Medications

Medication Name	Strength	Dose	How Often
Example: Aspirin	81mg	1 tablet	daily

Patient Name: _____ DOB: _____ Date: _____

HEALTH SCREENINGS

Women Only

☐ Mammogram Date: _____ Where: _____

☐ Pap Smear Date: _____ Where: _____

☐ Bone Density Date: _____ Where: _____

Men Only

☐ PSA/Prostate Screening Date: _____

☐ Screening for aneurysm Date: _____ Where: _____

Everyone

☐ Colonoscopy Date: _____ Where: _____

☐ Stool Test/Cologuard Date: _____ Where: _____

☐ Eye Exam Date: _____ Where: _____

☐ Dental Exam Date: _____ Where: _____

☐ Low Dose Lung CT Date: _____ Where: _____

☐ Other Screening: _____ Date: _____

IMMUNIZATION HISTORY

Vaccine	Date Received	Vaccine	Date Received
Flu Shot		Shingles	
COVID-19		Hepatitis B	
Tetanus/Tdap		HPV	
Pneumonia		Other:	

Additional Comments: _____

SOCIAL HISTORY

Tobacco Use: ☐ Nonsmoker ☐ Former Date quit: _____

☐ Current- Circle type (cigarettes, cigars, smokeless tobacco, vape) – quantity per day_____

Alcohol Use: ☐ None ☐ Occasional ☐ Daily Drinks per day: _____

Recreational Drug Use: ☐ No ☐ Yes _____

Occupation: _____

Exercise: ☐ None ☐ 1–2 Days/Week ☐ 3–5 Days/Week

Patient Name: _____ DOB: _____ Date: _____

OTHER PHYSICIANS OR SPECIALISTS YOU SEE

Please include your eye care professional and your dentist.

Providers Name	Specialty & location

PATIENT SIGNATURE

I certify the above information is true and complete to the best of my knowledge.

Patient Signature: _____**Date:** _____

OFFICE USE ONLY

Reviewed By: _____Date Reviewed: _____

Medications Reconciled: ☐ Yes ☐ No

Health Maintenance Updated: ☐ Yes ☐ No