THE WINSTON CLINIC, P.A.

PATIENT INFORMATION

Name:_____

Preferred Name:_____

Address:_____

_____

City, State:_____

Zip Code:_____

Phone:_____ **(CELL)**

Phone:_____ **(HOME)**

Emergency Contact Name and Phone:

_____

Date of Birth:_____

Sex: M____ F___

Social Security #:_____

Martial Status:

MARRIED:___ SINGLE:___ DIVORCED:___ WIDOW:___

Email:_____

PREFERRED CONTACT METHOD:

CALL:___ TEXT:___ EMAIL:___

Pharmacy(s):_____

_____

_____

GUARDIAN INFORMATION:

under 18 years old

MOM:_____

DAD:_____

OTHER:_____

EMPLOYMENT STATUS

(List place of employment)

EMPLOYED:_____

PART TIME:_____ .

SELF-EMPLOYED:_____

RETIRED:____

UNEMPLOYED:___

DISABLED:____

INSURANCE:

Name of Insurance(s):_____

_____

SUBSCRIBER(Name of Person that Carries Insurance):

_____

_____

Subscribers ID:_____

Subscribers DOB:_____

Subscribers Address:_____

_____

Subscribers Phone #:_____

Subscribers Social Security#:_____

Patient Name_____ DOB:_____

NEW PATIENT PAPERWORK- The Winston Clinic, P.A.

1) Tobacco/Nicotine Status: (circle one) **current former never**

Circle which type: **cigarette cigar smokeless tobacco vape**
If you circled one of the above: How many packs/items per day? ____
What year did you start? ____ What year did you quit? ____
Years smoked? ____ Exposed to second-hand smoke? __YES __NO

2) HIV high risk behavior? __YES __NO

3) How many caffeinated beverages do you have daily? (tea, soda, coffee) _____**beverages daily**

4) Has your biological mother suffered a heart attack **before age 65?** __ YES __ NO

5) Has your biological father suffered a heart attack **before age 55**? __ YES __ NO

6) Do you exercise? __ Yes __ NO If YES:

How many times weekly? _____ What type of exercise? (cardio, weights, yoga, etc.) _____

7) How often do you wear your seatbelt? (circle one) **100% 75% 50% 25% 0%**

8) Are you exposed to the sun? (circle one) **Frequently Occasionally Rarely Remotely**

9) Do you drink alcohol? __ YES __ NO **TYPE:**_____

IF YES: On average: How often do you have drink alcohol? (Circle one)
-Monthly or less 2-4 times/month 2-3 times/week 4 or more times/week
How many standard drinks of alcohol do you have in a typical day? _____
How often do you have 6 or more alcoholic drinks on one occasion? (Circle one)
- Less than monthly Monthly Weekly Daily Or Almost daily

10) Illegal drug use? __ YES __ NO

If yes was checked, what type? _____

Preventative measures: DATE DOCTOR/FACILITY

Last Pap Smear _____ _____
Last Colonoscopy _____ _____
Last Mammogram _____ _____
Last annual labwork _____ _____

PAST SURGERIES/PROCEDURES

APPROX DATE PAST SURGERIES DOCTOR/FACILITY

_____
_____
_____

Patient Name_____ DOB:_____

PAST MEDICAL HISTORY

11) Have you been diagnosed with any of the following? (please circle)

Anemia	Cirrhosis	Hepatitis C	Seizure Disorder
Anxiety	Colon Cancer	High Cholesterol	Thyroid Problems
Asthma	Other Cancer (please	High Blood Pressure	Tuberculosis
Atrial Fibrillation	list):_____	Thyroid Problems	Recurrent UTI
Autoimmune Disorder	Heart Disease	Kidney Stone	Hysterectomy
Liver Disease	Crohn's Disease	Heart Attack	Other:_____
Brain Tumor	Blood Clots	Neurological Disorder	_____
Breast Cancer	Depression	Osteoarthritis	_____
Chronic Kidney	Diabetes	Osteoporosis	_____
Disease	Diverticulitis	Gastric Ulcers	_____
Stroke	Acid Reflux	Peripheral Vascular	_____
Cerebrovascular	Hepatitis A	Disease	_____
Disease	Hepatitis B	Rheumatoid Arthritis	

12) Have you had any problems with anesthesia? ___YES ___NO

13) Please list any prescription and OTC medications you are currently taking or provide list.

Medication	**Strength**	**How often?**	**Why?**
(Example) Lisinopril	*10mg*	*1 daily*	*high blood pressure*

14) Please list any drug allergies and what reaction you have. Include food allergies, latex and dye allergies.

Allergy	**Reaction**	**Allergy**	**Reaction**

15) Do you see any other doctors? (Cardiology, Pulmonology, Urology, etc.) Please list below.

Name	**Specialty**	**Facility**

16) Who was your last Primary Care Provider & where are they located? Please list phone number if possible.

_____

THE WINSTON CLINIC, P.A.

P.O. BOX 100
SHERIDAN, AR 72150
PHONE (870)942-3000 FAX (870)942-3005

Authorization for the Use or Disclosure of Protected Health Information

AUTHORIZATION SECTION PATIENT DATE OF BIRTH _____

I, _____, hereby authorize the use and disclosure of all my health information.

(PRINT PATIENT NAME)

I authorize the following persons to make and receive these disclosures of my health information:

_____ _____

(name of person(s) that can request your health information)(include relationship to patient)(EX: John Doe- Dad)
PLEASE PRINT NAME LEGIBILY

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of this form and returning it to The Winston Clinic, P.O. Box 100, Sheridan, AR 72150. I further understand that any such revocation does not apply to the extent that persons authorized to use of disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire in **ONE YEAR** from signing this document.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment, my eligibility for benefits, etc., will not depend in any way on whether I sign this authorization or not.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

I understand that The Winston Clinic, P.A. will receive compensation for the uses and disclosures that I have authorized.

Signature: _____ Date:_____

REVOCATION SECTION

I hereby revoke this authorization.

Signature:_____ Date:_____

THE WINSTON CLINIC, P.A.

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Financial Policy

_____

(PRINT PATIENT NAME AND DATE OF BIRTH)

Thank you for choosing The Winston Clinic, P.A. as your healthcare provide. We are committed to providing you and your family with the best available medical care. In our ongoing process to make sure that all your medical needs are met, our billing department will be available to discuss our fees and this policy with you.

We ask that all responsible parties read and sign our financial policy as well as complete the patient information forms prior to seeing the physician.

Payments for all services will be due at the time services are rendered. In order to serve you better we accept cash, checks, Visa, Mastercard, and Discover. As a courtesy to you, it is the policy of The Winston Clinic, P.A. to bill your insurance carrier, although you are ultimately responsible for the entire bill. As the responsible party, please understand:

Please initial each statement below:

_____ Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company.

_____ Fees for services, which include unpaid balances, deductibles and co-payments, are due at the time of service. Returned checks and unpaid balances may be subject to collection placement and collection fees.

_____ I understand and agree that if I fail to make any payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency by The Winston Clinic, P.A. I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

_____ The above does not apply for those patients that are considered Workers' Compensation. However, be advised that as a compensation patient, you may be held responsible for charges in the event that your claim is disputed.

_____ I understand The Winston Clinic will no longer bill Medicaid or ARKids First as a secondary. I will be responsible for all co-pays, co-insurance, and deductibles. Effective 4/17/18.

_____ I understand if I discuss anything outside of my insurance wellness benefits during my wellness exam I may be charged for a separate office visit.

At The Winston Clinic, P.A., we understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing. If you have any questions, please call (870) 942-3000.

I, _____, agree to the financial policy.

(Guarantor Signature)

No-Show, Late and Cancellation Policy

The Winston Clinic, P.A. is committed to providing exceptional care. Your appointments and well-being are very important to us. We understand that emergencies occur resulting in a missed appointment. Unfortunately, when you do not call to cancel, we are unable to accommodate our patients waiting for an appointment. Out of respect for our staff and our patients, we require at least one (1) hour notice prior to scheduled appointment.

The first no show will be documented and a courtesy call to inform you of you missed appointment.

The second no show will be a call notifying you of your missed appointment and incur a fee of $30 applied to your account.

The third no show may result in our practice terminating care with you.

Scheduled Appointment Time

We know your time is valuable, and ours is too. All patients are asked to arrive fifteen (15) minutes prior to their scheduled appointment to allow for the check in process. Patients arriving ten (10) minutes after their scheduled appointment time may be required to reschedule. We will try to accommodate if you are late as best as possible, but cannot compromise on the quality and timely care provided to our other patients. The $30 fee may still be applied in addition to any co-pay or office visit charges.

I acknowledge that I have read and agree to the no-show, late and cancellation policy of The Winston Clinic, P.A.

_____ _____

Print Patient Name Patient Date of Birth

_____ _____

Signature Date

Effective: 2/1/2019 Revised 2/3/2020

Authorization to Release Medical Information
THE WINSTON CLINIC P.A., P.O. Box 100, Sheridan, AR 72150
Phone: (870)942-3000 Fax: (870)942-3005

I authorize the health care provider named below to release all medical records upon request to The Winston Clinic, P.A. to the address above at the time of the request.

☐ S. Winston, M.D. ☐ L. Garner, NP ☐ B. HENSLEY, NP

☐ D. Dixon, PA-C ☐ J. Garner, NP ☐ L. HENSLEY, NP ☐ A.COVERT,NP

Provider Name/Clinic: _____

Address: _____

Phone #: _____ **Fax #:** _____

Patient's Name: _____

Social Security #: _____ **DOB:** _____

Address: _____

Signature: _____ **Date:** _____

If not signed by the patient, please indicate relationship:

☐ Parent or Guardian of minor patient

☐ Guardian or conservator of an Incompetent patient

☐ Beneficiary or personal representative of deceased patient

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CONSENT FOR TELEHEALTH SERVICES

1. I understand that my health care provider wishes to engage in a telehealth visit or series of visits. I understand that these encounters will not be the same as a direct patient/health care provider visit because I will not be in the same room as my health care provider. Instead, we will communicate using two-way simultaneous audio-visual technology ("the technology").
2. I understand that I have the right to refuse to participate in any telehealth encounter at any time or to end it at any point during the encounter. I understand that if I do not wish to participate in a telehealth encounter I will need to either make an appointment for an in-person visit with my provider or seek care at the closest emergency department if I believe that my symptoms warrant that level of care. I further understand that my provider may not be able to accommodate an in-person visit and there may be a delay in my care if I choose an in-person visit.
3. I understand that my health care provider can discontinue the telehealth encounter if he or she believes that this technology does not meet the standard of care necessary to address my medical concerns. If that happens, I understand that I will need to either make an appointment for an in-person visit with my provider or seek care at the closest emergency department if I believe that my symptoms warrant that level of care.
4. I understand how the technology will be used to conduct any telehealth encounters with this practice. I also understand that, with this technology, there is a risk of interruption and technical difficulties.
5. I have had the opportunity to ask questions about telehealth encounters and the technology. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language that I understand.
6. I understand that I will be told the identity of everybody who will be in the room with my healthcare provider during any telehealth encounter and that those people will be present only because my health care provider has determined that their presence is necessary to assist in my medical treatment according to the applicable standard of medical care.
7. I have been told whether my provider is licensed to provide medical care in the state where I am located. If they are not licensed in the state where I am located, I consent to receive telehealth services anyway because the provider is fully licensed in the state where they are located.
8. I understand that I will be responsible for any copays and coinsurance that apply to my telehealth encounter (s). On the day of my appointment I understand my co-pay will be deducted from my card on file. If I have a deductible plan, I understand my visit total will be deducted after my appointment. I understand I will receive a call from The Winston Clinic with the total amount that was deducted. If I do not answer I understand my receipt will be mailed to me.
9. This consent will remain valid for six (6) months from the date of my first telehealth visit.

_____	_____	_____
PRINT NAME	DOB	DATE

_____	_____
SIGNATURE	EXPIRATION DATE

Scott D. Winston, M.D.
Danielle F. Dixon, PA-C
Lauren K. Garner, APRN
Brittney D. Hensley, APRN
Joshua A. Garner, APRN
Laura S. Hensley, APRN
Amber C. Covert, APRN