Wabash General Hospital
People you know, helping people you love

**Wabash General Primary Care**
1123 Chestnut Street
Mt. Carmel, IL 62863
Phone (618) 263-4376  Fax (618) 262-2281
Lauren Croft, M.D. - Levi McDaniel, M.D. - Thomas Selby, M.D.
Diane DeStefano, APN, ACNP-BC - Clay Walker, MSPAS, PA-C

Date: _____

Dear _____,

Thank you for choosing Wabash General Primary Care. To assure we have all necessary information to assess your health care needs, and secure your appointment, we ask patients to complete the following items prior to being scheduled for a new patient appointment with our office.

- ✓ All paperwork must be completed, signed, and returned to our office.
- ✓ Signed authorization to release medical records from previous PCP/Hospital.
- ✓ Photo ID/Driver's license (required at first visit).
- ✓ Current Insurance card(s) (required at each visit).
- ✓ Power of Attorney and/or Living Will documentation (if applicable).
- ✓ Complete the Patient Portal form; if you have an active email address.

The following items are required upon the day of your appointment:

- ✓ Insurance card(s) must be presented at each visit.
- ✓ All current medications in their original bottles.
  - ➢ Please note: No refills will be authorized for medications that are not presented upon appointment.
- ✓ All co-pays are expected at the time of visit.
- ✓ Cell phones must be silenced while patients are being seen by our providers.
- ✓ No smoking and No firearms are allowed on WGH Primary Care property; this includes the parking area.
- ✓ Showing up late for a scheduled appointment may result in cancellation of that appointment.
  - ➢ Please note: No show appointments will be addressed as stated per our No Show/Cancellation Policy.
- ✓ **Patients should be advised that it is not the practice of our providers to prescribe long-term narcotics or benzodiazepines. The need for use of these medications will be determined on a case-by-case basis.**

I have read and agreed to the above requirements for my new patient appointment.

_____ _____

**Signature of Patient or Patient Representative** **Date**

**Appointment Date & Time:** _____ **Provider:** _____

*This will be filled in by staff upon receipt of the completed new patient packet.*

Wabash General Hospital
People you know, helping people you love


## Wabash General Primary Care

1123 Chestnut Street
Mt. Carmel, IL 62863
Phone (618) 263-4376  Fax (618) 262-2281
Lauren Croft, M.D. - Levi McDaniel, M.D. - Thomas Selby, M.D.
Diane DeStefano, APN, ACNP-BC - Clay Walker, MSPAS, PA-C


---

**Notice to the Public: Provider-Based Status**

Thank you for choosing Wabash General Hospital Primary Care for your medical needs. You are visiting a facility that functions as an outpatient department of Wabash General Hospital. This posting is intended to inform patients about our provider-based billing practices and how it affects you as a patient.

**What does "provider-based" or "hospital outpatient" billing mean?**

"Provider-based" or "hospital outpatient" billing refers to the billing process used for services provided in a hospital outpatient facility. This is where the physician/provider is employed by the hospital and the hospital owns the space and provides support staff for the physician/provider. It breaks out the charges for each office visit or service, with part of the total for the main person you see (your provider), and the rest for the place (building, support staff, equipment and other overhead).

**How does this affect my billing?**

Patients may receive a charge **from the hospital and the physician/provider in a hospital outpatient setting**. If a patient has insurance, each patient's insurance plan is unique to that patient and contracted provider. Some insurance companies may cover both hospital charges and doctor charges and some may not.

**How does this affect a patient who has Medicare or Medicaid?**

In a hospital based clinic, Medicare and Medicaid patients may receive two separate bills for services provided in the office- one from the provider and one from the hospital. Depending on the clinical service being provided, additional out-of –pocket expenses for Medicare and Medicaid patients may be incurred in the "Provider-Based" facility.

**What if a Medicare or Medicaid patient has secondary insurance coverage?**

Co-insurance and deductibles may be covered by a secondary insurance policy. Check with your benefits or insurance company for details related to your secondary coverage. For instance, you may ask whether the secondary insurance company covers facility charges or provider-based billing. If it does, ask what percentage of the charge is covered. Verify what your hospital outpatient insurance benefits are, as they typically are applied toward your deductible and coinsurance.

**Medical Records**

Medical Records for patients treated in either the outpatient clinics or the hospital should be available for review at the different sites of care. This includes all provider sites below and their providers plus Wabash General Hospital as well.

**Which WGH locations/departments are "provider-based"?**

WGH Orthopaedic & Sports Medicine Department (Mount Carmel Location)
WGH General Surgery Department
WGH Oncology Department
WGH Primary Care

**In Summary:** Receiving care at Wabash General Hospital's "Provider-Based" locations may result in a facility charge as well as a professional or physician charge for outpatient services and/or procedures. These charges will be reflected on the patient statement you receive for services provided. Your insurance plan will determine the impact this has on your out-of-pocket expenses. Wabash General Hospital is not unique in billing this method.

Patients are advised to review their insurance benefits or contact their insurance provider to determine what their policy will cover and identify any out-of-pocket expenses. For more information please contact our business office at (618) 262-8621.

# Wabash General Hospital

*People you know, helping people you love*


**Wabash General Primary Care**

1123 Chestnut Street
Mt. Carmel, IL 62863
Phone (618) 263-4376  Fax (618) 262-2281
Lauren Croft, M.D. - Levi McDaniel, M.D. - Thomas Selby, M.D.
Diane DeStefano, APN, ACNP-BC - Clay Walker, MSPAS, PA-C


**New Patient Information** Today's Date - _____

Full Name - _____

Date of Birth - _____ Age - _____ Gender - _____

SSN - _____ Marital Status - _____ Race - _____

Phone Number - _____

Email Address - _____

Address/City/State - _____

Employer Name & Address - _____

Emergency Contact Name/Number - _____

Emergency Contact Relationship/Date of Birth - _____

Do you want me to be your Primary Care Physician? - Yes / No

Who was your previous Primary Care Physician? Name - _____

Location - _____

## Insurance Information

Primary Insurance - _____

Primary Holder Name/DOB/SSN - _____

Policy #/ Group # - _____

Secondary Insurance - _____

Secondary Holder Name/DOB/SSN - _____

Policy #/ Group # - _____

I hereby authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical and or surgical benefits to include major medical benefits to which I am entitled to WGH photocopy is considered valid. I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges.

Signature: _____ Date: _____

Wabash General Hospital
People you know, helping people you love

**Wabash General Primary Care**
1123 Chestnut Street
Mt. Carmel, IL 62863
Phone (618) 263-4376  Fax (618) 262-2281
Lauren Croft, M.D. - Levi McDaniel, M.D. - Thomas Selby, M.D.
Diane DeStefano, APN, ACNP-BC - Clay Walker, MSPAS, PA-C

## Guarantor- only complete if you are under 18 or have a POA (person responsible for bill)

Guarantor Name- _____

Date of Birth- _____ Age- _____ Gender- _____

Relationship to Patient- _____ SSN- _____

Phone Number- _____ Work Number- _____

Home Address/City/State/Zip- _____

Employer Name/Employer Address- _____

### Financial Agreement and Authorization for Treatment

I understand that I am seeking treatment from Wabash General Hospital's Provider-Based Clinic. I am aware that there may be separate charges for the hospital and physician. Depending on the services provided, additional out-of-pocket expenses may be incurred. Patients are advised to review their insurance benefits or contact their insurance provider to determine what their policy will cover.

Wabash General Primary Care will complete forms at the patient's request. A $15 fee will be charged for each set of forms, payment is due prior to completion.

Patient Name Printed: _____ Date: _____

Patient/Guardian Signature: _____

**Wabash General Primary Care**
1123 Chestnut Street
Mt. Carmel, IL 62863
Phone (618) 263-4376  Fax (618) 262-2281
Lauren Croft, M.D. - Levi McDaniel, M.D. - Thomas Selby, M.D.
Diane DeStefano, APN, ACNP-BC - Clay Walker, MSPAS, PA-C

## Privacy Questionnaire and Policy Disclosure Statement

Please note: If this section is not completed, we are unable to discuss these issues or release information to anybody other than you (and those entities allowed by law).

1. List the family member(s) or other person(s) that we may inform of your medical condition, treatments, test results, appointments, and account information.

   Name: _____Phone Number: _____
   Name: _____ Phone Number: _____
   Name:_____Phone Number: _____

2. Please print the address of where you would like correspondence from our office to be sent **if other than your home address.**
   _____
   _____

3. Can confidential messages be left on your home telephone answering machines? Yes/No
4. Can confidential messages be left on your cellular phone? Yes/No
5. What is your preferred method of contact? _____
6. I understand that Wabash General Hospital Primary Care will contact me by telephone and other electronic means (text, e-mail, Next MD patient portal, etc. if necessary to remind me of my upcoming appointments._____ **Patient or guardian's initials.**

I _____ (the patient/ patient's legal representative/guardian) hereby grant permission to Thomas D Selby, M.D. / Levi McDaniel, M.D./Diane DeStefano, APN, ACNP-BC/ Clay Walker PA-C/Lauren Croft, MD to perform such examinations and medical and therapeutic procedures professionally deemed necessary or advisable for the patient's diagnosis and treatment.

**I verify that I have been offered and/or received a copy of Wabash General Hospital Primary Care Notice of Privacy Practices (NPP) in regards to the HIPAA Privacy Act.**

Patient Name Printed: _____ Date: _____

Patient/Guardian Signature: _____

Wabash General Hospital
People you know, helping people you love

**Wabash General Primary Care**
1123 Chestnut Street
Mt. Carmel, IL 62863
Phone (618) 263-4376  Fax (618) 262-2281
Lauren Croft, M.D. - Levi McDaniel, M.D. - Thomas Selby, M.D.
Diane DeStefano, APN, ACNP-BC - Clay Walker, MSPAS, PA-C

**Please complete the following questionnaire. Your answers will help with providing your care. We will review this form with you during your examination. All information will be kept confidential.**

Patient Name: _____

What Pharmacy do you use? _____

What is the reason for your visit today? _____

_____

History of your current problem (when it started, your symptoms and treatment, if any):

_____

_____

Caffeine Use: What Kind: _____How Much:_____

Tobacco Use:  Yes / No  _____ Current  _____Former  _____Years of Use

Type: Smoking: How Often:_____Packs per Day:_____

Snuff (between lower lip and gum): How Often:_____Cans per Day:_____

Chew (between cheek and gum): How Often:_____Cans per Day:_____

Quit Date: _____

Alcohol Use: Yes / No  _____Current  _____Former

How Often: _____How Much:_____

Illicit Drug Use: Yes / No  _____Current  _____Former

How Often: _____How Much:_____

Have you had any recent falls in the last 12 months:  Yes  /  No

**Wabash General Primary Care**
1123 Chestnut Street
Mt. Carmel, IL 62863
Phone (618) 263-4376  Fax (618) 262-2281
Lauren Croft, M.D. - Levi McDaniel, M.D. - Thomas Selby, M.D.
Diane DeStefano, APN, ACNP-BC - Clay Walker, MSPAS, PA-C

Dominant Hand:  Left / Right
What is your occupation?_____

Does your occupation involve exposure to any hazardous materials, chemicals or body fluid contact, etc.?
Yes/No If yes, please give details: _____

_____

**Your medical history**: Please check all previous illness or conditions below.

__ Chronic Obstructive Pulmonary Disease
__ Asthma
__ Hypertension (High Blood Pressure)
__ Coronary Artery Disease
__ Myocardial Infarction (Heart Attack)
__ Congestive Heart Failure
__ Hyperlipidemia (High cholesterol)
__ Diabetes
__ Chronic Renal Failure
__ Obesity
__ Arthritis
__ Syncope (passing out)
__ DVT (Deep Vein Thrombosis)
__ Hypothyroidism (Underactive Thyroid)
__ Thyroid Nodule (Lump in Thyroid Gland)
__ Hyperparathyroidism
__ Hashimoto's Disease (thyroid gland inflammation)
__ Hypercalcemia
__ Osteopenia (Mild Bone loss)
__ Osteoporosis (Severe Bone Loss)
__ Vitamin D Deficiency
__ Kidney Stones
__ Hyperthyroidism (Overactive Thyroid)
__ Heart Disease
__ Vascular Disease

Do you have a history of prior cancers? If so, what type? _____

_____

Do you or have you ever sunbathed?  Yes / No.  If so how often? _____

Do you or have you ever used a tanning bed? Yes / No. If so how often?_____

Any history of sunburns? Yes/No if yes, estimated number of sunburns_____

Any other problems not listed? _____

_____

Wabash General Hospital
People you know, helping people you love

**Wabash General Primary Care**
1123 Chestnut Street
Mt. Carmel, IL 62863
Phone (618) 263-4376  Fax (618) 262-2281
Lauren Croft, M.D. - Levi McDaniel, M.D. - Thomas Selby, M.D.
Diane DeStefano, APN, ACNP-BC - Clay Walker, MSPAS, PA-C

**Have you had any of the following immunizations?**

Pneumonia vaccine: circle yes/no/unsure  When?_____

Influenza vaccine: circle yes/no/unsure  When?_____

MMR (measles, mumps, and rubella): circle yes/no When?_____

Hepatitis B: circle yes/no When?_____

Shingles vaccine: yes/no When?_____

Tetanus Toxoid: circle yes/no When?_____

Tuberculosis Skin Test: circle yes/no When?_____

**Surgical History:**

| Type: | Approximate Date: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Have you ever been hospitalized? Yes / No Hospital name: _____

Please tell us the reason why and when? _____

_____

Have you ever had a colonoscopy? Yes/No/Unsure If yes, when & where?_____

**Blood Transfusion**: Yes / No  If Yes: When _____

Do you see any specialists?_____

_____

**Wabash General Primary Care**
1123 Chestnut Street
Mt. Carmel, IL 62863
Phone (618) 263-4376  Fax (618) 262-2281
Lauren Croft, M.D. - Levi McDaniel, M.D. - Thomas Selby, M.D.
Diane DeStefano, APN, ACNP-BC - Clay Walker, MSPAS, PA-C

**Do you have any Advanced Directives?** _____

**Females**:

- If adult, have you had a mammogram? Yes/No If yes, when & where?
  _____
- Are you on any form of birth control now?
  _____
- Are you interested in discussing long-term, reversible birth control options like Nexplanon or IUDs?
  _____

**Family Medical History: Include all known medical history including: cardiovascular disease, cancer, gastrointestinal disease, liver disease, etc.**

| | Age | Diseases | If Deceased, Cause of Death |
|---|---|---|---|
| **Father** | _____ | _____ | _____ |
| **Mother** | _____ | _____ | _____ |
| **Sisters** | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| **Brothers** | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| **Children** | _____ | _____ | _____ |
| | _____ | _____ | _____ |

Wabash General Hospital
People you know, helping people you love

**Wabash General Primary Care**
1123 Chestnut Street
Mt. Carmel, IL 62863
Phone (618) 263-4376  Fax (618) 262-2281
Lauren Croft, M.D. - Levi McDaniel, M.D. - Thomas Selby, M.D.
Diane DeStefano, APN, ACNP-BC - Clay Walker, MSPAS, PA-C

## Check if your blood relatives had any of the following:

**Relationship to you: Paternal/Maternal/Alive/Deceased**

**Arthritis** _____
**Asthma** _____
**Cancer** _____ **Type:** _____
**Colon Polyps** _____
**Diabetes** _____
**Drug/Alcohol Dependency** _____
**Heart Disease** _____
**High Blood Pressure** _____
**Kidney Disease** _____
**Stroke** _____
**Tuberculosis** _____
**Other (specify)** _____

**Current Medications** (include any prescribed over the counter items including: hormones, vitamins, supplements and herbs):

| **Name of Medicine:** | **Dosage:** | **How often:** | **Tablet/Capsule:** | **Reason for taking:** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Wabash General Hospital

*People you know, helping people you love*


**Wabash General Primary Care**

1123 Chestnut Street

Mt. Carmel, IL 62863

Phone (618) 263-4376  Fax (618) 262-2281

Lauren Croft, M.D. - Levi McDaniel, M.D. - Thomas Selby, M.D.

Diane DeStefano, APN, ACNP-BC - Clay Walker, MSPAS, PA-C


---

## Are you allergic to anything? __ Yes __ No

**List all ALLERGIES to anything and describe your reaction.**

| **Allergies:** | **Reaction:** |
|---|---|
| **Food:** | |
| | |
| **Drug:** | |
| | |
| | |
| **Latex:** | |

Patient/Guardian Signature: _____ Date: _____

Physician/Healthcare Provider Signature: _____ Date: _____

**Wabash General Primary Care**
1123 Chestnut Street
Mt. Carmel, IL 62863
Phone - (618) 263-4376  Fax (618) 262-7970
Levi McDaniel, M.D. Thomas Selby, M.D. Lauren Croft, M.D.
Diane DeStefano, APN, ACNP-BC Clay Walker, MSPAS, PA-C

---

## Authorization for Release of Medical Information

Patient Name: _____

Date of Birth:_____Social Security #: _____

I hereby authorize release of my medical records and information from: _____

_____

To: _____

Address: **1123 Chestnut St., Mt Carmel, IL 62863**

Fax number: **618-262-7970** Phone number: **618-263-4376**

Covering the periods of health care from _____to_____

The following information is to be released: (Please check all that apply)

__ Complete Health Records
__ Office visits/progress notes
__ Laboratory Tests
__ X-Ray Reports
__ Billing Information
__ EKG
__ Operative Reports
__ other (please specify)
__ Sensitive Information (results of HIV, psychiatry information, etc.)

*I understand that this authorization can be revoked by me in writing at any time unless action has already been taken. I also understand that this authorization will expire one year from the date signed unless expiration date is indicated here.*

_____

Signature of Patient: _____ Date: _____

Or other authorized person: _____ Relationship: _____

Witness: _____Date: _____

**Wabash General Primary Care**
1123 Chestnut Street
Mt. Carmel, IL 62863
Phone - (618) 263-4376  Fax (618) 262-7970
Levi McDaniel, M.D. Thomas Selby, M.D. Lauren Croft, M.D.
Diane DeStefano, APN, ACNP-BC Clay Walker, MSPAS, PA-C

# CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you must provide more than 24 hours notice when possible. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made in less than 24 hours notice, it is difficult to offer that slot to other people that may need to be seen for an acute visit.

Patients who do not show for their appointments without a call to cancel an office appointment or a procedure appointment will be considered as **NO SHOW**. Patients who **No-Show two (2) visits in six (6) months or three (3) or more visits in a 12 month period**, may be dismissed from the practice upon the physician's discretion. Thus, they will be denied any future appointments. Upon patient termination, the office will provide acute visits only for a 45 day period in order for the patient to obtain a new primary care provider. WGH Primary Care will also help assist the patient in the process of obtaining a new primary care provider if the patient so chooses.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about appointment cancellations should be directed to our office at 618-263-4376.

Please sign that you have read, understand and agree to this Cancellation and No Show Policy.

_____ Date of Birth: _____
Patient Name (Please Print)

_____ _____
Signature of Patient or Patient Representative Date

**Wabash General Primary Care**
1123 Chestnut Street
Mt. Carmel, IL 62863
Phone - (618) 263-4376  Fax (618) 262-7970
Levi McDaniel, M.D. Thomas Selby, M.D. Lauren Croft, M.D.
Diane DeStefano, APN, ACNP-BC Clay Walker, MSPAS, PA-C

---

## NEXTMD PATIENT PORTAL TERMS AND CONDITIONS

We think it is important for you to know how we handle information we communicate via the internet. This Terms and Conditions statement, together with the Notices of Privacy Practices you receive from the WGH provider(s) you visit, outlines our practices governing NextMD and our sensitivity to your right to privacy. We reserve the right to revoke access to NextMD at any time for any reason.

I understand that WGH providers may send me messages via NextMD. These messages may contain information that is important to my health and medical care. It is my responsibility to monitor these messages. By entering my valid and functional email address, I have enabled WGH providers to notify me of messages sent to my NextMD inbox. I understand that I will be notified via e-mail when there is new medical information to be viewed on NextMD. This means that any person with access to my e-mail (shared email accounts or if you share your email username and password) will be able to see this notification. This could include my spouse, my employer or anyone else that can access my e-mail account. Although no private medical information will be sent, the notification that new medical information is available by accessing NextMD may be information that I would not want others to know. Thus, I understand that I should take this into account when providing an email address for NextMD notifications.

I understand that I may view my upcoming appointments on NextMD. However, if I have an upcoming procedure I understand the time of my surgery is tentative and the Wabash General Hospital Surgery Department will call me with my hospital arrival time and procedure time closer to the date of my operation.

**Patient Initials**: _____

I agree to update my email address on NextMD if it changes.

I agree that all communication through NextMD will be in regard to my own health condition(s). I understand that the contents of any message may be stored in my permanent medical record. No WGH provider assumes responsibility for health information or services used by persons other than the NextMD enrollee.

NextMD ID and Password: I understand that I will create a unique identification (ID) code and password to be used to access my health information. I understand that this ID and password are unique codes that identify me in the NextMD system. Inquiries and entries that I make via NextMD will be logged with my identity.

I understand that it is extremely important that I keep the ID and password that I use to access NextMD completely confidential. I understand that anyone with access to my ID and password will be able to access my confidential medical information, and will be able to read my messages and send new messages as if they were me. If at any time I feel that the confidentiality of my password has been compromised, I will change it by going to NextMD>login using your current user ID and password>Settings tab> Account Settings>Edit Password. If a WGH provider discovers that I have inappropriately shared my ID or password with another person, or that I have misused or abused my NextMD access privileges in any way (such as using inappropriate abusive language), my participation in NextMD may be discontinued without prior notice.

**Wabash General Primary Care**
1123 Chestnut Street
Mt. Carmel, IL 62863
Phone - (618) 263-4376  Fax (618) 262-7970
Levi McDaniel, M.D. Thomas Selby, M.D. Lauren Croft, M.D.
Diane DeStefano, APN, ACNP-BC Clay Walker, MSPAS, PA-C

---

**NEXTMD PATIENT PORTAL DISCLAIMER**

I understand that NextMD may not be available to me at all times due to system failures, back-up procedures, maintenance, or other causes beyond the control of WGH providers. Access is provided on an "as-is, as-available" basis and WGH providers do not guarantee that I will be able to access NextMD at any particular time. I understand that WGH providers take no responsibility for and disclaim any and all liability arising from how I use the information I obtain from NextMD. I understand that NextMD contains selected, limited medical information from a patient's medical record and that NextMD does not reflect the complete content of the medical record. I understand a paper copy of my medical record can be requested from my provider. I understand I should consult with a physician or other healthcare provider regarding my own condition and how NextMD content may or may not apply to me. I understand I should never change or stop any course of treatment prescribed by a provider without first consulting with him or her.

Healthcare Agents (Medical Power of Attorney): I understand that if I have a Healthcare Agent/Medical Power of Attorney and if a physician taking care of me determines I am unable to make decisions myself; my healthcare agent will have complete access to my medical and mental health records, to include the patient portal. I understand the portal could contain sensitive lab results and behavioral health history.

I understand that WGH providers take no responsibility for any and all liability arising from any inaccuracies or defects in software, communication lines, virtual private network , the internet or my internet service provider, access system, computer hardware or software, or any other service or device that I use to access NextMD. During times when NextMD is unavailable, other communication methods should be used to contact my health care provider. I understand that if I have a problem accessing NextMD, I can contact WGH Primary Care during normal business hours at 618-263-4376.

I further understand that WGH providers cannot be held responsible for: (a) absolute security of all electronic communication transmissions between me and any WGH provider; (b) unauthorized disclosure resulting from my failure to log out of an active session; (c) unauthorized disclosure resulting from someone other than me reading information printed by me from NextMD; (d) unauthorized disclosure resulting from personal computer settings or installed software products that may compromise information security; or (e) similar events outside control of WGH provider(s).

Email Address: _____ Initial: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____