ROCK RIVER
COMMUNITY CLINIC

NEW PATIENT DETAILS

Welcome to Rock River Community Clinic! We are grateful to be your healthcare home. Please see below for important highlights related to your care at RRCC.

CONNECTING WITH YOU

- Current phone number for calls and reminder texts
- Up-to-date mailing address
- Up-to-date e-mail address (if applicable)

GETTING STARTED

- Valid photo ID
- Document that shows your address (utility bill, phone bill)
- Insurance card (if applicable)

**For minors, a parent or guardian must attend the first appointment and provide a photo ID and proof of address

APPOINTMENT REMINDERS

- You will receive reminder calls and texts for your appointment
- If you cannot keep that appointment, please contact RRCC staff as soon as possible
- Refer to our no-show reminders page for missing scheduled appointments

PATIENT COSTS

- Financial assistance is available for all patients through our Sliding Fee Discount Program.
- Enroll in Badgercare/Medicaid with the help of our Care Navigators
- Have insurance? Check to see if RRCC is in your network!

REFERRALS TO HEALTHCARE PARTNERS

- You may be referred for services outside of our clinic.
- Our referral team will work with you to schedule the appointment and help you enroll in any financial assistance programs, if necessary.

ROCK RIVER COMMUNITY CLINIC

Welcome to Rock River Community Clinic (RRCC)!

Whitewater Medical Clinic: 1461 W Main St Whitewater, WI 53190 (262) 472-6839
Hours: Monday/Tuesday 9am-6pm; Wednesday 9am-3pm; Thursday 8am-4pm; Friday 8am-4pm

Watertown Medical Clinic: 415 South 8th St Watertown, WI 53094 (920) 206-7797
Hours: Monday/Tuesday 9am-6pm; Wednesday 9am-3pm; Thursday 8am-4pm

Fort Atkinson Dental Clinic: 520 Handeyside Lane Fort Atkinson, WI 53538 (920) 563-4372
Hours: Monday through Thursday 8am-4pm

Our after-hours medical line is 262-472-6839 to be connected to a trained nurse through our on-call service. Call 4 Health (24 hours a day). Messages can be left in English or Spanish.

Medical Services

- General Primary Care
- Annual Wellness Exams
- Diagnostic Testing/Laboratory
- Acute Injuries or Illnesses
- Women's Health/Wellness Exams
- Family Planning
- Well Childs & School Physicals
- Diabetic Education & Care

Behavioral Health Services

For established medical patients, RRCC also offers integrated behavioral health services on select days. Integrated behavioral health services help connect you with a trained provider who will engage in short term counseling support to help you meet your treatment goals and help connect you with additional service supports beyond your primary care provider.

While we accept most private health insurance plans listed below for your medical & behavioral health needs, please be sure to call the number on the back of your health insurance card to verify if your provider is considered **within the RRCC network**.

Aetna*	Alliance	Anthem	Chorus Community Health Plan
Humana	Icare	Medicaid/BadgerCare[1]	Managed Health Services*
Medicare	Molina	Quartz	United Health Care

*insurance plans that **do not** cover our Behavioral Health Services

Dental Services

- Screenings/cleaning
- Fillings
- Root canals
- Oral cancer screenings
- Periodontal therapy
- Exams & x-rays
- Tooth extractions

Medicaid/BadgerCare is the **only** dental insurance we accept. Our staff will help determine your dental needs and connect you to the appropriate dental service starting point.

[1] Medicaid/Badgercare is also known as "Forward Health" in Wisconsin.

Patient Communication

Effective communication is an essential part of ensuring you receive the best care possible. Our RRCC team is dedicated to providing consistent, clear communication to our patients and we ask for your partnership in providing the same. We request all patients*:

- Keep their cell phone operational at all times
- Have voicemail and text message capabilities
- Keep a current cell phone number on file with RRCC

**Please let our staff know if you need assistance or support with these tasks.*

If you reach our team outside of regular office hours, we request you include the following details in your message so our team can properly return your message: **your full name, your date of birth, reason for your call, best way to contact you, hours we can reach you.**

Appointment Attendance

Regular attendance at appointments ensures healthcare issues are addressed, questions are answered, and it can prevent small medical concerns from developing into larger ones. While we recognize that emergencies can arise, we ask that you make every effort to attend your scheduled appointment.

RRCC staff will send a confirmation text/call one week before your appointment, and then an additional follow-up reminder 1-2 days prior to the appointment. **If you are unable to keep your appointment, we request you call us as soon as possible to reschedule**. Your communication will ensure our staff is available to assist other patients who may need to be seen that day.

If you miss an appointment without contacting our staff in advance, it is considered a “no show.” For full details, please review our no-show policy included in this folder.

Patient Referrals

If you require healthcare services that are not provided by RRCC or cannot be performed in our clinics, RRCC staff will refer you to one of our healthcare partners best suited for your needs. For speciality care, there may be instances where you will need to be referred outside of your county of residency. Depending on your healthcare coverage, you may receive a bill for the cost of these services.

If a referral does need to be made to another provider or clinic, RRCC staff will schedule that appointment for you. Please communicate with RRCC staff about your referral appointments so our staff can assist you in completing any needed Community Care/Financial Assistance programs to the referred healthcare facility for a discount. If you have questions on that bill or are unable to pay it, please contact RRCC as quickly as possible so our Referral Team can work to assist you.

Prescription Assistance Program

RRCC patients have access to potential financial support for discounted prescription medications. To apply for support, an application must be submitted to the pharmaceutical company that produces your medication, along with proof of income of those in your household who are employed. RRCC staff will work with you directly to ensure your documents are accurate and complete before submission. RRCC staff do not have control over the approval process, but will support you through it.

Quality, Affordable Healthcare

RRCC is proud to welcome ALL patients into our medical clinics, regardless of insurance coverage or ability to pay. RRCC medical clinics accept Medicare, Medicaid (BadgerCare/Forward Health), most private health insurance plans, and offer a sliding fee discount program to those not enrolled in any healthcare coverage plans.

Medicare & Medicaid (BadgerCare/Forward Health):
Patients with Medicare or BadgerCare coverage simply need to provide the plan details to RRCC at your first appointment. Please be sure to bring a copy of your insurance card along with a form of identification to that appointment. For patients enrolled in a qualified BadgerCare program at the time of their visit, there is no cost for your visit.

Enroll TODAY: Enrolling in Medicare (ages 65+) or BadgerCare (all ages) can save you significant costs. Our RRCC Care Navigators will work with you to determine your eligibility and help you apply!

Your co-payment due at the time of service will vary depending on your insurance plan. Depending on your private insurance, you may be eligible to also enroll in our Sliding Fee Discount Program to manage high copays or deductible costs.

Sliding Fee Discount Program:
For patients without insurance, RRCC provides a sliding fee discount based on your household income and family size. Before your first appointment, you will be offered the opportunity to meet with an RRCC Care Navigator to apply for this financial assistance. You will need to provide proof of your full household income. Applications are good for one year. After one year, a new screening will need to be completed to continue the financial assistance.

Each application should include proof of income from each member of your household who is currently employed. You will have 30 days from the date of your 1st appointment to provide RRCC staff with the proof of income for your household. Please know that if you cannot access all of the required documents, RRCC staff will work with you to properly identify and support your application.

Proof of income documentation includes one but is not limited to any and/or all of the following:

- Minimum of 3 Most Recent Pay Stubs ranging at least one month
- Payroll & Earnings Verification Statement
- One month of bank statements showing income deposits
- Most current 1040 tax form or W-2's
- Income Self Declaration

Payment Plan Options:
For any bill over $20, you are welcome to set up a payment plan with our financial team. Payments can be set up in automatic installments or paid as you are able on a monthly basis. To maintain an active payment plan, the agreed upon payment amount is due each month with a minimum of $10 or more to continue to receive care.

ROCK RIVER
COMMUNITY CLINIC

MEET YOUR RRCC MEDICAL PROVIDERS

With decades of experience in patient care, our RRCC medical providers are equipped to meet the full needs of everyone who calls RRCC their healthcare home.

EXPERT TEAM

- Qualified Doctors
- Highly-skilled Nurse Practitioners
- Experienced Nursing Staff
- Compassionate Care Navigators
- Experienced Support Staff
- Bilingual Team Members

DR. DONALD WILLIAMS, MD

Medical Director

Whitewater Clinic

48 years of experience

Enjoys fly fishing & woodworking

MARY BECK METZGER, APNP

Nurse Practitioner

Watertown clinic
Whitewater clinic

24 years of experience

Enjoys camping & gardening

DR. MICHAEL GRAJEWSKI, MD

Family Doctor

Watertown Clinic

40 years of experience

Enjoys bicycling & running

ELIZABETH STEVENSON, APNP

Nurse Practitioner

Whitewater Clinic

9 years of experience

Enjoys DJing techno parties

Whitewater Medical Clinic
1461 W. Main Street
Whitewater, WI 53190
262.472.6839

Watertown Medical Clinic
415 S. 8th Street
Watertown, WI 53094
920.206.7797

ROCK RIVER COMMUNITY CLINIC

YOUR HOSPITAL PARTNER

At Rock River Community Clinic, we work closely with our hospital partners to ensure you have access to the care you need. From lab work to specialty care, RRCC will assist you in contacting the appropriate hospital system, based on the community you live in.

Patients must reside within the hospital's service area to receive financial assistance

Watertown Regional Medical Center	
City	**Zip Code**
Watertown	53094 53098
Waterloo	53594
Lake Mills	53551
Johnson Creek	53038
Ixonia	53036
Reeseville	53579

Fort Memorial Hospital/ Fort Healthcare	
City	**Zip Code**
Fort Atkinson	53538
Jefferson	53549
Cambridge	53523
Palmyra	53156
Helenville	53137
Whitewater	53190

Questions? Talk with our Referrals Team today!

Whitewater Medical Clinic
1461 W. Main Street
Whitewater, WI 53190
262.472.6839

Watertown Medical Clinic
415 S. 8th Street
Watertown, WI 53094
920.206.7797

HEALTH HISTORY (Historia de salud)

ROCK RIVER COMMUNITY CLINIC

Appointment Date:_____

Provider:_____

****

Please complete this form as accurately as possible. (Por favor, complete este formulario con la mayor precisión posible)

Patient Name (Nombre del paciente) _____

Date (Fecha):_____ Phone Number (Número de teléfono): _____

Address (Dirección): _____

Date of Birth (Fecha de nacimiento _____ Age (Edad) _____ Guardian (Tutor legal): _____

Medical History (Historia de salud)

Check all the conditions that apply to you (Marque todos los problemas de salud que tenga).

HEART **CORAZÓN**	☐ High blood pressure Presión alta ☐ High cholesterol Colesterol alto ☐ Heart attack Ataque al corazón ☐ Chest pain Dolor en el pecho ☐ Heart surgery Cirugía del corazón	**LUNGS** **PULMONES**	☐ Asthma Asma ☐ Tuberculosis ☐ Shortness of breath Dificultad para respirar
OTHER **OTRO**	☐ Stroke Ataque ☐ Blood Clot Coágulo sanguíneo ☐ Osteoporosis ☐ Recurrent bladder infections Infecciones vesicales recurrentes ☐ Kidney trouble Problemas renales ☐ Liver trouble Problemas hepáticos ☐ Diabetes ☐ Arthritis Artritis ☐ Thyroid Tiroides ☐ Stomach pain/ulcer Dolor/Úlcera de estómago ☐ Cancer Cáncer		

Current Medications (Include blood thinners and over the counter medications such as aspirin, antacid, etc)
Medicamentos que está tomando (incluya anticoagulantes y medicamentos como la aspirina, antiácidos, etc.)

_____

_____

Are you allergic to any medications?(¿Es alérgico a algún medicamento?) YES / SI _____ NO _____

If YES, name the medication(s) and describe the reaction. (En caso afirmativo, nombre el medicamento y describa la reacción.) _____

_____

List any (Enumere las condiciones de salud que se apliquen en su caso)

Past surgeries - Cirugias en el pasado _____

Chronic Illness - Enfermedades crónicas _____

Cancer treatment - Tratamiento del cáncer _____

Past fractures or injuries - Heridas o fracturas _____

See backside (Vea la página posterior)

Family History (Historia familiar)

Have you or a family member had - Usted o algún miembro de su familia ha tenido

	Yes - Sí	No	Relationship to you (Relación con usted)	What type (Qué tipo)
High blood pressure Presión alta	☐	☐		
Diabetes	☐	☐		
Heart attack Ataque al corazón	☐	☐		
Heart failure Insuficiencia cardíaca	☐	☐		
Cancer Cáncer	☐	☐		
Mental health diagnosis Diagnóstico de salud mental	☐	☐		

Health Behavior (Comportamiento de salud)

	Yes(Sí)	No					
Do you drink alcoholic beverages? (¿Consume bebidas alcohólicas?)	☐	☐	1-2 times/year (1-2 veces/año)	1-2 times/month (1-2 veces/mes)	1-2 times/week (1-2 veces/semana)	3-5 times/week (3-5 veces/semana)	Daily (A diario)
Do you use products that contain nicotine? (¿Utilizas productos que contienen nicotina?)	☐	☐	cigarettes (cigarrillos)	Chewing tobacco (mascando tabaco)	Vape (vapear)	e-cigarettes (cigarrillos electronicos)	
Do you use recreational drugs? (¿Usa drogas recreativas?) e.g. Marijuana (por ejemplo marihuana)	☐	☐					
Do you feel safe in your home? (¿Te sientes seguro en tu casa?)	☐	☐					
Is anyone harming you? (¿Alguien te está haciendo daño?)	☐	☐					

General Health (Salud general)

Last physical exam? ¿Último examen físico? **Date/Fecha** _____

Last dental exam? ¿Último examen dental? **Date/Fecha** _____

	Yes(Sí)	No
Have you been screened for colon cancer? ¿Le han hecho pruebas de detección de cáncer de colon?	☐	☐
Have you had any immunizations? ¿Ha recibido alguna vacuna?	☐	☐
Can you provide a copy of your immunization record? ¿Puede proporcionar una copia de su registro de vacunación?	☐	☐
Are you visiting from another country? ¿Estás de visita desde otro país?	☐	☐

How long have you been in the USA? ¿Cuánto tiempo llevas en Estados Unidos? _____

Women's Health (Salud de la mujer)

	Yes(Sí)	No
Are you/could you be pregnant? ¿Estás o podrías estar embarazada?	☐	☐
Are you taking any form of birth control? ¿Está usando algún tipo de método anticonceptivo?	☐	☐
Have you ever had a mammogram? ¿Alguna vez te has hecho una mamografía?	☐	☐

Last PAP/pelvic exam? ¿Último examen Papanicolaou? _____

To the best of my knowledge, the information above is accurate.
La información brindada es correcta a mi mejor saber y entender.

Patient Signature (Firma del paciente el dia de hoy)_____

ROCK RIVER
COMMUNITY CLINIC

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(TO OBTAIN INFORMATION FROM ANOTHER SOURCE)

PATIENT INFORMATION:

Name of Patient/Previous Names Date of Birth

Street Address

City, State, Zip

Phone Number

AUTHORIZES DISCLOSURE BY:

Name of Health Care Provider/Plan/Other

Street Address

City, State, Zip

Phone:_____ Fax:_____

FOR THE FOLLOWING DATES:

DISCLOSURE OF HEALTH INFORMATION TO:

Rock River Community Clinic
1461 W. Main Street STE B
Whitewater, WI 53190
P: 262-472-6839 **F:** 262-472-6802

INFORMATION TO BE DISCLOSED: *Identify below the specific information you are authorizing to be disclosed.*

- ☐ Hospital Records
- ☐ ED Report (last 3)
- ☐ Patient Demographics
- ☐ Specialty Clinic notes
- ☐ Lab Report (3 years)
- ☐ Current medication and allergy list
- ☐ Progress report (past year)
- ☐ Radiology Report
- ☐ Healthcare Power of Attorney

DISCLOSURES REQUIRING SPECIAL CONSENT: *In compliance with Federal/Wisconsin Statutes, which require special permission to disclose otherwise privileged information, I am authorizing that the following information also be disclosed: Check that apply.*

- ☐ Drug/Alcohol Abuse/Treatment
- ☐ HIV/AIDS
- ☐ Mental Health/Behavioral Health Conditions

PURPOSE FOR DISCLOSURE: *Please provide specific purpose for disclosure or check applicable category.*

- ☐ Continue Care
- ☐ Disability Determination
- ☐ Legal
- ☐ Workers Compensation
- ☐ Transfer to New Provider
- ☐ Insurance/Claim Purposes
- ☐ Vocational Rehab.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to Inspect or Receive a Copy of the Health Information to Be Used or Disclosed -- I understand that I have the right to inspect or receive a copy (may be provided at a reasonable fee) of the health information I have authorized to be used or disclosed by this authorization form. **Right to Receive a Copy of This Authorization** -- I understand that if I agree to sign this authorization, I may receive a copy. **Right to Refuse to Sign This Authorization** -- I understand that I am under no obligation to sign this form and that Rock River Community Clinic may not condition treatment, payment, enrollment, in a health plan or eligibility for health care benefits on my decision to sign this authorization except regarding a) research related treatment, b) health plan enrollment or eligibility, c) the provision of health care is solely for the purpose of creating PHI for disclosure to a third party. ****Right to Withdraw This Authorization** -- I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Rock River Community Clinic's Health Information Department. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by the Federal privacy standards. ***HIV Test Results**: I understand my HIV test results may be released without authorization to persons/organizations that have access under State laws and a list of those persons/organizations is available upon request. ****WI Statutes 5130 and 252.15** requires patient authorization to disclose health information for payment purposes. **Copy of Facsimile (FAX) Valid as an Original.**

This information has been disclosed to you from records protected by Federal (42 CFR Part 2) and Wisconsin (51.30) confidentiality rules. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any of information to criminally investigate or prosecute any alcohol or drug abuse patient.
Expiration Date: This authorization is good until the following dates _____ or 1 year from the date signed.

Signature of Patient/Legal Rep:	Relationship to Patient:	Date:
RRCC Employee Witness:		Date:

RELEASE BY: ☐ US MAIL ☐ FAX:

New Patient Appointment:

STAT