Welcome to Advanced Wound Institute!

We are so happy you found us. To ensure the best possible care, it all starts with getting to know you! Please fill out the information below to the best of your ability. As always, if you have questions, please ask. We are here to help!

Patient Name: _____ Date of Birth: _____

Wound History

Wound 1

Location: _____

When did it start? _____

How did it start? _____

If more than one would present:

Wound 2

Location: _____

When did it start? _____

How did it start? _____

Wound 3

Location: _____

When did it start? _____

How did it start? _____

Treatment History:

1. What do you clean your wounds with?

   _____

2. What do you apply on your wounds?

   _____

3. Are you taking any antibiotics? ☐ Yes ☐ No

   If so which one? _____

   Who prescribed it? _____

What is your pain scale?

No Pain	Mild	Moderate	Severe	Very Severe	Worst Pain Possible
0	1 – 2	3 – 4	5 – 6	7 – 8	9 – 10

Patient Health Checklist

Current Symptoms:
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Fatigue
- ☐ Cough
- ☐ Anemia
- ☐ Hypotension (Low blood
- ☐ Cirrhosis (Liver problems)
- ☐ Thyroid Disease
- ☐ Diabetes
  Last HgbA1C _____
- ☐ Kidney Disease
- ☐ Dialysis
- ☐ Lupus
- ☐ Cancer/Chemotherapy
- ☐ Hyperlipidemia
  (High cholesterol)

Neurological:
- ☐ Seizures
- ☐ Vertigo
- ☐ Weakness
- ☐ Numbness/Tingling
- ☐ Stroke
- ☐ Paraplegia/Quadriplegia

Psychological:
- ☐ Depression
- ☐ Anxiety
- ☐ Memory Loss
- ☐ Bipolar

Respiratory:
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Asthma
- ☐ Chronic Obstructive
- ☐ Pulmonary Disease (COPD)
- ☐ Chronic Sinus Problems/Congestion
- ☐ Pneumothorax (Collapsed lung)
- ☐ Sleep Apnea
- ☐ Tuberculosis (Infection in the lungs)

Cardiovascular:
- ☐ Chest discomfort
- ☐ Palpitations
- ☐ Arrhythmia
- ☐ Atrial Fibrillation
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
  (Heart disease)
- ☐ Myocardial Infarction
  (Heart attack)
- ☐ High Blood Pressure
  (Hypertension)

Musculoskeletal:
- ☐ Arthritis
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Weakness

Extremities:
- ☐ Edema (Swelling)
- ☐ Hemophilia
  (Bleeding Disorder)
- ☐ Lymphedema
  (Swelling in legs/arms)
- ☐ Deep Vein Thrombosis
  (Blood clot in leg)
- ☐ PAD (Peripheral Arterial Disease)
- ☐ Raynaud's Syndrome
- ☐ Scleroderma
- ☐ Rheumatoid Arthritis
- ☐ PVD (Peripheral Vascular Disease)
- ☐ Phlebitis (Inflammation of the veins in your legs)

Infectious Disease:
Exposed to or been recently diagnosed with… (circle one)

C-diff (Clostridium difficile)	YES	NO
Hepatitis	YES	NO
HIV	YES	NO
MRSA	YES	NO

Hospitalization History

Date	Reason you were in the hospital	Facility

Surgeries

Date	Procedure

Medication / Allergy History

Please list all medications you take routinely (including current and previous chemotherapy)

Name of Medication	Dosage (mg)	How Many Times Daily

Allergies to Medication/Other:	Reaction:

Social Use

Smoking status: ☐ Current Smoker ☐ Former Smoker ☐ Non-Smoker

If you are a current smoker, are you interested in quitting? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

If yes how many drinks per day? _____

How many drinks per month? ☐ 0 – 5 drinks ☐ 6 or more

Do you use recreational drugs? ☐ Yes ☐ No

If yes what type? _____

Demographic Information

Patient's Name: _____
Last First Middle Initial

Address: _____ Apt #: _____ City: _____ State: _____Zip: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female Social: _____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____

Permissions: ☐ Home ☐ Mobile ☐ Work

I grant permission to have voice and/or text messages which may contain personal health information left on the phones selected.

Emergency Contact: _____ Phone #: _____

Relationship to Patient: _____

Release of Records: *I hereby authorize Advanced Wound Institute to disclose my medical records including information regarding my condition, treatment, imaging, and diagnosis to my emergency contact.*

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Occupation: ☐ Employed ☐ Retired ☐ Student ☐ Full Time ☐ Part Time

In order for our healthcare practice to meet the qualification requirements under the American Recovery and Reinvestment Act of 2009 we are required to obtain the following information:

1. Ethnicity: ☐ Hispanic or Latino/a ☐ Non-Hispanic ☐ Do not wish to respond
2. Race: ☐ American Indian or Alaska Native ☐ Black or African American
   ☐ Asian ☐ White ☐ Other Race ☐ Hispanic
   ☐ Native Hawaiian or Other Pacific Island ☐ Do not wish to respond
3. Language: ☐ English ☐ Spanish ☐ Other: _____

List Preferred Pharmacy

Pharmacy Name: _____ Cross Streets: _____

Phone Number: _____ Fax: _____

Physician Information

Primary Care Physician

Physician Name: _____ Location: _____

Office Phone: _____ Fax: _____

Referring Physician (if different than PCP)

Physician Name: _____ Location: _____

Office Phone: _____ Fax: _____

Additional Physicians

Vascular

Physician Name: _____ Location: _____

Office Phone: _____ Fax: _____

Podiatry

Physician Name: _____ Location: _____

Office Phone: _____ Fax: _____

Home Health

Company Name: _____ Nurse's Name: _____

Office Phone: _____ Fax: _____

Release of Records: I hereby authorize Advanced Wound Institute to disclose my medical records including information regarding my condition, treatment, imaging, and diagnosis to the physicians above.

Insurance Information

Primary Insurance: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Policyholder's Name: _____ Other: _____

Date of Birth: _____ Phone: _____ Social: _____

If different from patient:

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Employer: _____ Phone: _____

Secondary Insurance: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Policyholder's Name: _____ Other: _____

Date of Birth: _____ Phone: _____ Social: _____

If different from patient:

Address: _____ Apt #: ____ City: _____ State: _____ Zip: _____

Employer: _____ Phone: _____

<u>Responsible Party</u> – Person responsible for receiving the financial statements.

☐ **SELF**

☐ **Other – Please complete information below**

Name: _____
Last First Middle Initial

Address: _____ Apt #: ____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Date of Birth: _____ Email Address: _____

Insurance and Payments

Financial Responsibility: Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurance carrier will be your responsibility, except as limited by a specific network agreement with your insurance carrier, if such an agreement is in place.

If you do not have health insurance, or if your health insurance will not pay for services rendered by us or if you notify us not to contact or bill your insurance company, you are considered a self-pay patient. Your changes will be based on our current self-pay fee schedule (available at our front desk). Payment is due in full at the time of service.

By initialing this section, you acknowledge that you have received a copy of our Financial policies to review.

Initials:

Agreement to Receive Wound Care

Between _____ and _____

Patient Name Provider Name

I understand that I am being seen for wound care treatment in order to assist healing of my wound(s). This treatment is known to be effective only when provided on a regular basis. Lapses in my treatment, such as missed days or sporadic days, failure to comply with the plan of care can result in this therapy becoming less effective or ineffective. Thus, I understand that in order for my treatment to be worthwhile, it is important that I receive treatment as scheduled and follow treatment instructions provided.

Wound Care Services: Wound care treatment may include, but shall not be limited to sharp debridement, dressing changes, biopsies, skin grafts, off-loading, Negative Pressure therapy and compression devices.

Risks/Side Effects: May include, but not be limited to infection, ongoing pain and inflammation, potential scarring, possible damage to blood vessels or surrounding areas such as organs and nerves, bleeding, allergic reaction to medications, removal of healthy tissue, prolonged healing or failure to heal.

Patient Identification and Wound Images: Patient understands and consents that image (digital, film, etc..), may be taken of Patient and all Patient's wounds with their surrounding anatomic features. Patient further agrees that their referring physician or other treating physicians may receive communications, including these images, regarding Patient's treatment plan and results. The images are considered part of the medical record and will be handled in accordance with federal laws regarding the privacy, security, and confidentially of such information. The patient understands that Advanced Wound Institute will retain the ownership right to these images, but that the patient will be allowed access to view them or obtain copies. Patient understands that these images will be stored in a secure manner that will protect privacy and that they will be kept for the time period required by law. Patient waives any, and all rights to royalties or other compensation for these images. Images that identify the Patient will only be released and/or used outside Advanced Wound Institute upon written authorization from the Patient or Patient's legal representative.

I agree to the following conditions*: (initial each line signifying agreement)*

_____**I will appear for treatment as scheduled.**

1. If I am unable to appear for a scheduled appointment, I will notify AWI staff <u>at least 24 hours prior</u> to the appointment.
2. I understand that in order to be compliant with my plan of care, it is imperative that I come to my appointments on time. If I have more than 3 same day cancellations or no shows during my course of treatment I may be discharged for noncompliance.
3. I will make every effort possible to reschedule for the same week so that I remain compliant with my plan of care. If I have more than 2 reschedules within a month I may be discharged for noncompliance.
4. I understand if I am more than 10 minutes late for an appointment, it will count as a same day cancellation.

_____**I will follow the treatment instructions provided to me and I will actively seek assistance when I find myself unable to comply with the plan of care.**

1. I will complete all wound care as prescribed, or I will notify AWI staff immediately for any reason of inability to complete any portion of care plan as prescribed.
2. I agree that I am responsible for notifying the AWI staff immediately if I have any problems, questions, or concerns regarding my wound and how I should care for it.
3. If transportation is a concern, I will notify the AWI staff so every effort can be made towards getting to all appointments on time as scheduled.

_____I understand that a violation of any of these conditions may result in my discharge from the AWI's program.

_____I agree to be an active participant in my care.

_____ _____

Patient Name/Signature Date

Advanced Medical Directive and Power of Attorney

Do you have an Advance Medical Directive? ☐ Yes ☐ No (You Must Check One)

If yes, Name: _____ Phone: _____

Do you have a Healthcare Medical Power of Attorney? ☐ Yes ☐ No (You Must Check One)

If yes, Name: _____ Phone: _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize Advanced Wound Institute to release of any/all information regarding my diagnosis and treatment to the following person(s) below, until I notify you otherwise:

Name(s): 1. _____ 2. _____ 3. _____

I understand that the information I have agreed to release to the aforementioned party may include sensitive clinical information obtained during the dates listed below. These may or may not include treatment of substance or other abuse, HIV, psychiatric disorders, sexually transmitted diseases, etc., unless herein except:

Additional Notifications

A copy is available at our front desk and online at: www.healmywounds.com

Notice of Privacy Practice

By initialing this section, I acknowledge that I have received a copy of the notice of privacy practice which includes a statement of patient's rights to review.

Initial:

Code of Conduct

By initialing this section, I acknowledge that I have received a copy of the code of conduct statement to review.

Initial:

Use of Media

By initialing this section, I acknowledge that I have received a copy of the use of Media statement to review.

Initial:

By signing below, I voluntarily consent to all medical and surgical treatment performed by Advanced Wound Institute (I also consent to routine services, diagnostic procedures, medical treatment, other health care services deemed necessary by the health care providers treating me. I understand that the practice of medicine and surgery is not an exact science, and that diagnosis and treatment may cause injury or even death. I understand that I have a right to consent or to refuse to consent to any proposed surgery, procedure, or treatment, and to discuss it with my health care provider. I understand that if an employee or any individual associated with Advanced Wound Institute is exposed to my blood or bodily fluids, I will be tested for hepatitis viruses and the Human Immunodeficiency Virus (HIV).

The information on this form is accurate to the best of my knowledge.

_____ _____

Signature of Patient / Legally Authorized Representative Date

_____ _____

Printed Name of Patient / Legally Authorized Representative Date