Admit Date: Location: /

LifeCare Hospital **Patient Consent to Treatment** **Admission Form**	(Patient Name)

1. **CONSENT TO MEDICAL AND SURGICAL PROCEDURES**
The patient identified above consents to the procedures that may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examination, medical and surgical treatment or procedures, anesthesia, or hospital services rendered for the patient under the general and special instructions of the patient's physician. <u>The patient also consents to the use of photographs and other imaging for treatment and Quality Assurance purposes, and understands that such images are considered a part of either the patient medical record or Quality Assurance records.</u>

2. **NURSING CARE**
Nursing services will be provided based on the patient's care requirements at a level to ensure patient's safety and that total nursing care needs are met.

3. **NOTICE OF PHYSICIAN AVAILABILITY**
LifeCare provides competent, fully trained staff that monitors patients' conditions 24 hours a day. There may be times when a physician is not physically present in the facility. On occasions when a physician is not physically present, patients with health care emergencies will be assessed and treated by qualified medical personnel, with on call physician support available. The on call physician is available via the telephone, pager, or electronic monitoring. Depending on the nature of the condition, the on call physician will either come to the hospital to assess the patient, deliver orders to the staff over the phone, or when special services are indicated, and have the patient transferred to another facility.

4. **LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIAN**
All physicians furnishing services to the patient are independent contractors with the patient and are not employees or agents of the hospital. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician. The patient's physician has the responsibility to obtain the patient's informed consent, when required, to medical treatment or special diagnostic or therapeutic procedures.

5. **RELEASE OF INFORMATION**
The hospital may release to the public certain basic information, including the patient's name, and general condition without prior authorization. If a patient or a patient's personal representative does not wish such information to be released, he/she must make a specific written request for the information to be withheld. A separate form for this purpose may be obtained upon request.

The patient authorizes the release from his or her medical records of such information (medical or psychiatric) as may be required by: Any health, sickness, and accident carrier, workman's compensation body, or agency (social, welfare, governmental) which is legally responsible for, or which the hospital has good cause to believe is responsible for, all or any part of the hospital's charges and/or professional fees;
Any physicians or other health care facilities rendering professional care to the patient; or, any Peer Review or other organization responsible for reviewing care under the law.

The patient also agrees that the hospital and/or physician may obtain from any source and examine, discuss and disclose my medical records and information, including medical history, examinations, diagnoses, treatments and HIV or AIDS information to treating hospital personnel and agents, other health care providers, medical researchers, medical record auditors, professional committees, care evaluators and governmental agencies. This consent to release and obtain information will be valid for a period not to exceed one year or until revoked by the patient or their authorized representative, except in so far as actions that have already been taken.

6. PERSONAL VALUABLES

The hospital is not responsible for any items of value that the patient maintains possession of. For convenience of its patients, the hospital maintains a safe for the storage of small amounts of cash and other valuables, and may provide temporary safe guarding of such items where appropriate. However, it is understood that the hospital strongly recommends that all patient valuables of any size and amount not be kept in the hospital. In any case, the maximum liability of the hospital for loss of any personal property which is deposited with the hospital for safekeeping is limited to five hundred dollars ($500.00) unless a written receipt for a greater amount has been obtained from the hospital by the patient.

7. FINANCIAL OBLIGATIONS - NOTICE

The undersigned agrees that, in return for the services to be rendered for the patient, the undersigned hereby individually obligates him/her to pay the account of the hospital in accordance with the regular rates and terms of the hospital. However, if the patient is eligible to receive benefits under a health care service plan with which this hospital has contracted, the patient shall not be obligated to pay for services covered under the plan which is paid for pursuant to the contract. If any excess funds remain after payment in full of the charges for services rendered for this hospital visit, the undersigned hereby authorizes the hospital to apply such excess funds toward any non-covered services and/or other outstanding account(s) which the patient may have with hospital for any prior services rendered and for which the undersigned is responsible. Should the patient's account become delinquent and be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts may be charged interest at the maximum rate allowed by law.

HEALTH CARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTH CARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR CO-PAYMENTS, COINSURANCE, DEDUCTIBLES, AND NON-COVERED SERVICES. SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF-NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT THE WEBSITE ADDRESS OF YOUR HEALTH PLAN OR BY CALLING THE CUSTOMER SERVICE TELEPHONE NUMBER OF YOUR HEALTH PLAN. YOU MAY ALSO REQUEST INFORMATION FROM YOUR HEALTH PLAN PROVIDER AS TO WHAT CIRCUMSTANCES YOU MAY BE RESPONSIBLE FOR PAYMENT OF ANY AMOUNTS NOT PAID BY YOUR HEALTH PLAN PROVIDER.

I understand that while I am a patient at this hospital if services are provided by a physician or other provider that does not participate in my health care plan, I may be responsible for charges in excess of what my health care plan would otherwise pay.

8. ASSIGNMENT OF INSURANCE OR HEALTH PLAN BENEFITS TO HOSPITAL

The undersigned assigns and hereby authorizes, whether he/she signs as agent or as patient, direct payment to the hospital of all insurance and health plan benefits otherwise payable to or on behalf of the patient for this hospitalization or for outpatient services, including emergency services if rendered, at a rate not to exceed the hospital's regular charges. The undersigned, whether he/she signs as agent or as patient, assigns to the hospital any and all rights he or she may have against a health insurance plan relating to services provided at the hospital, whether based on express or implied contract or upon statute, including but not limited to any rights authorizing the collection of damages or penalties related to the insurance company's failure to timely or expeditiously pay a claim. It is agreed that payment to the hospital pursuant to this authorization by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligations under the policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment and for charges paid directly by a health insurance company to the undersigned or family members. The undersigned acknowledges that if a health insurance company disregards this assignment provision and fails to pay the hospital directly for whatever reason, the hospital will vigilantly pursue all payment recovery remedies available at law and the undersigned shall pay actual attorney's fees and collection expenses related thereto.

9. ASSIGNMENT OF INSURANCE OR HEALTH PLAN BENEFITS TO PHYSICIANS

The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to any physician of any insurance or health plan benefits otherwise payable to or on behalf of the patient for professional services rendered during this hospitalization or for outpatient services, including emergency services if rendered, at a rate not to exceed such physician's regular charges. It is agreed that payment to such physician pursuant to this authorization by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligations under the policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

10. MEDICARE PATIENT'S RELEASE OF INFORMATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the hospital, any governmental agency, and any agent of any of the foregoing to release any information needed to act on this request or to verify my Medicare eligibility. I request that payment of authorized benefits be made in my behalf. I assign payment for the unpaid charges of the physician(s) for whom the hospital is authorized to bill in connection with its services. I understand I am responsible for any remaining balance not covered by other insurance.

11. CHAMPUS/MEDICARE NOTICE

Champus/Medicare will not pay for private rooms unless medically justified, personal convenience items, diagnostic admissions for tests or hospital stays not medically necessary. My signature below acknowledges my receipt of the information regarding Champus/Medicare from the hospital.

12. ADVANCE DIRECTIVE ACKNOWLEDGEMENT STATEMENT

I have been advised of the law and hospital policy regarding Advanced Directives and Patient Rights and have been given information regarding this subject.

	YES	NO		YES	NO
I have executed a Living Will			I have executed a Durable Power of Attorney		
I have given my physician and/or the hospital my declaration			I want a Living Will and would like the hospital's assistance.		
I understand that my declaration will not be honored until I have given the appropriate documents to my physician and/or the hospital.			I have received and have read a copy of the Patient Rights and Responsibilities Form		
I have identified myself as an organ donor					

13. HEALTH MAINTENANCE ORGANIZATION ("HMO") ACKNOWLEDGEMENT

	YES	NO		YES	NO
I have informed the hospital if I am currently a Member of an HMO, Medicare or otherwise.			I may become an HMO member, either Medicare or otherwise, during this hospital stay.		

I certify that I have read the foregoing, received a copy thereof, have been given an opportunity to ask questions and am the patient, the patient's legal representative, or am duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Patient/Parent/Guardian/Conservator Printed Name ______________________

Patient/Parent Guardian/Conservator Signature ______________________

Date/Time: ______________________

If other than patient, indicate relationship: ______________________

Reason patient is unable to sign: ______________________

Witness Printed Name ______________________

Witness Signature ______________________

Date/Time: ______________________

Admit Date: Location: /

Family Contact List

Patient Name: ______________________________ Account#: ________

Primary Contact:

Name: ______________________________ Relationship: ______________

Home Phone: - - ______________________________ Work Phone: - - ______________

Cell/Pager: ______________________________ Other Phone: ______________

Secondary Contact:

Name: ______________________________ Relationship: ______________

Home Phone: - - ______________________________ Work Phone: - - ______________

Cell/Pager: ______________________________ Other Phone: ______________

Tertiary Contact:

Name: ______________________________ Relationship: ______________

Home Phone: ______________________________ Work Phone: ______________

Cell/Pager: ______________________________ Other Phone: ______________

Family Physician: ______________________________

Address: ______________________________ Phone: ______________

City, State, Zip: ______________________________ Fax: ______________

Referring Physician: ______________________________

Address: ______________________________ Phone: ______________

City, State, Zip: ______________________________ Fax: ______________

Comments: ______________________________

I understand, and do not object, that the individuals listed may be contacted by LifeCare employees during the course of my care. The communication may contain protected health information, and may relate to my condition, my ongoing care, or other information deemed necessary in the provider's professional judgment. Also, if I am unavailable or unreachable, they may be contacted to obtain necessary account or insurance information to facilitate payment.

☐ Family or Patient Identified representative and, if requested, Patient Physician notified of admission.

______________________________ ______________

Patient Signature or Representative **Date/Time**

______________________________ ______________

Staff Witness **Date/Time**

Location: /

Admit Date:

NOTICE OF PRIVACY PRACTICES

This pamphlet describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Our Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for health care is considered "Protected Health Information" (PHI). We are required by Privacy of Individually Identifiable Health Information of the Health Insurance Portability and Accountability Act (the "HIPAA privacy Rules") HIPAA to give you this Notice about our privacy practices that explains how, when and why we may use or disclose your PHI. Except in specified circumstances, we must use or disclose only the minimum necessary PHI to accomplish the intended purpose of the use or disclosure.

*We are required to follow the privacy practices described in the Notice though **we reserve the right to change our privacy practices and the terms of the Notice at any time**. You may request a copy of the new notice from any LifeCare Management Services Facility. It is also posted on our website per facility at www.lifecare-hospitals.com.*

What is Protected Health Information (PHI)?

PHI information means information created or received by a LifeCare Hospital and transmitted or maintained in written, electronic, or any other form that (A) relates to (i) your past, present or future health condition, (ii) the provision of health care to you, or (iii) your past, present, or future payment for the provision of health care; and (B) individually identifies you or could reasonably be used to identify you.

Will LifeCare Have Access to My PHI Information?

Yes. Your Protected Health Information will be obtained by your LifeCare physician, LifeCare's office staff and others outside of LifeCare that are involved in your care and treatment for the purpose of providing health care services to you.

When May LifeCare Use or Disclose My Protected Health Information?

The law permits LifeCare, and its vendors referred to as "business associates," to use or disclose Protected Health Information to carry out "treatment," "payment" and other "health care operations." LifeCare is not required to obtain an authorization from you or to notify you each time it uses or discloses your Protected Health Information for treatment, payment or health care operations purposes. The following are examples of the types of uses and disclosures of your Protected Health Information that LifeCare is permitted to make, but the examples are not meant to be exhaustive.

Treatment: "Treatment" means the provision, coordination, or management of health care and related services by health care providers, including the coordination or management of health care by a health care provider with a third party (such as an insurer of LifeCare), consultation between providers with respect to a patient, and the referral of a patient for health care from one provider to another. This includes the coordination, management of your health care with doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of patients at the hospital. For example,

1. LifeCare may disclose your Protected Health Information, as necessary, to a home health agency that provides care to you,

2. LifeCare may disclose Protected Health Information to other physicians who may be treating you,

3. Your Protected Health Information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you,

4. A LifeCare physician may need to tell a dietician if you have diabetes so that LifeCare can arrange for you the appropriate meals, or

5. LifeCare might disclose certain Protected Health Information to facilitate a pharmacy's filling of your prescription.

Different departments of the hospital also may share medical information about you in order to coordinate the different things that patients need, such as prescriptions, lab work and x-rays. In addition, LifeCare may disclose your Protected Health Information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your LifeCare physician, becomes involved by providing assistance with your health care diagnosis or treatment. LifeCare may also disclose medical information about you to people outside the hospital who may be involved in your medical care after you leave the hospital, such as family members, clergy or others LifeCare uses to provide services that are part of your care.

Payment: Your Protected Health Information will be used, as needed, to obtain "payment" for your health care services provided by LifeCare. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services LifeCare recommends for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. Another example is obtaining approval for a hospital stay, which may require that your relevant Protected Health Information be disclosed to a health plan to obtain approval for the hospital admission. Likewise, LifeCare may disclose your treatment to a health plan in order to obtain prior approval or to determine whether your plan covers the cost for the treatment.

Health Care Operations: "Health Care Operations" means those other functions and activities that LifeCare performs in connection with providing health care. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, credentialing, underwriting, auditing functions, and conducting or arranging for other business and administrative activities. For example, LifeCare may disclose your Protected Health Information to medical school students that are in training and seeing patients at our offices. Likewise, LifeCare will disclose your information to doctors, nurses, technicians, medical or nursing students, and other hospital personnel for review and learning purposes. LifeCare may use your medical information to review its treatment and services and to evaluate the performance of its staff in caring for patients. LifeCare may also combine medical and demographic information about many hospital patients in order to decide what additional services the hospital should offer, what services are not needed, and whether certain new treatments are effective. In addition, LifeCare may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. LifeCare may also call you by name in the waiting room when your physician is ready to see you. LifeCare will share your Protected Health Information with third party "business associates" that perform various activities (e.g., billing and transcription services) for LifeCare. Whenever an arrangement between Lifecare and a business associate involves the use or disclosure of your Protected Health Information, LifeCare will have a written contract with the business associate that contains terms that will protect the privacy of your Protected Health Information.

When May LifeCare Use or Disclose My Protected Health Information?

For uses and disclosures beyond treatment, payment and operations purposes we are required to have your written authorization, unless the use or disclosure falls within one of the exceptions described below. Authorization can be revoked at any time to stop future uses/disclosures except to the extent that we have already undertaken an action in reliance upon your authorization.

Uses and Disclosures of PHI From Mental Health Records Not Requiring consent or Authorization: The law provides that we may use/disclose your PHI from mental health records without consent or authorization in the following circumstances:

When required by law: We may disclose PHI when a law requires that we report information about suspected abuse, neglect or domestic violence, are relating to suspected criminal activity, or in response to a court order. We must also disclose PHI to authorities that monitor compliance with these privacy requirements.

For public health activities: We may disclose PHI when we are required to collect information about disease or injury, or to report vital statistics to the public health authority.

For health oversight activities: We may disclose PHI to our central office, the protection and advocacy agency, or another agency responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents, and monitoring of the Medicaid program.

Relating to decedents: We may disclose PHI related to a death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants. For research purposes: in certain circumstances, and under supervision of privacy board, we may disclose

PHI to central office research staff and their designees in order to assist medical/psychiatric research.

To avert threat to health or safety: In order to avoid serious threat to health or safety, we may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

For specific government functions: we May disclose PHI of military personnel, and veterans in certain situations, to correction facilities in certain situation to government benefit programs relating to eligibility and enrollment, and for national security reasons, such as protection of the President Uses and Disclosures of PHI From Alcohol and Other Drug Record Not Requiring Consent or Authorization The law provides that we may use/disclose your PHI from alcohol and other drug records with our consent or authorization in the following circumstances:

When required by law: We may disclose PHI when a law requires that we report information about suspected child abuse and neglect, or when a crime has been committed on the program premises or against program personnel, or in response to court order.

Relating to decedents: We disclose PHI relating to an individual's death if state or federal law requires the information for collection of vital statistics or inquiry into cause of death.

For research, audit or evaluation purposes: In certain circumstances, we may disclose PHI for research, audit or evaluation purposes.

To avert threat to health or safety: In order to avoid a serious threat to health or safety, we may disclose PHI to law enforcement when a threat is made to commit a crime on the program premises or against program personnel.

Will LifeCare Use or Disclose my PHI for Marketing Purposes?

While LifeCare does not anticipate using or disclosing your Protected Health Information for marketing purposes, under the HIPAA Privacy Rules, LifeCare may only make such uses or disclosures with your Authorization, unless LifeCare communicates with you in person or provides you with some promotional gift of nominal value, in which case your Authorization would not be required. In addition, LifeCare may send you information about its facilities and other products and services that LifeCare believes would be beneficial to you. However, you may contact LifeCare's Privacy Officer (referenced on the last page of this Notice) to request these materials not be sent to you.

Do I have the right to request additional restrictions on the uses or disclosures of my Protected Health Information?

Yes. You have the right to request additional restrictions relating to LifeCare's use or disclosure of your Protected Health Information beyond those otherwise required under the HIPAA Privacy Rules. Although LifeCare is not legally required to grant these requests, it is your right to make such a request. For additional information or to obtain the proper form for making such a request, please contact LifeCare's Privacy Officer (referenced on the last page of this Notice).

May I request that certain confidential communications of my Protected Health Information be made to me at alternate locations?

Yes. LifeCare may communicate your Protected Health Information to you in a variety of ways, including by mail or telephone. If you believe that LifeCare's communications to you by the usual means will endanger you or your health care and you would like LifeCare to make its communications that involve Protected Health Information to you at an alternate location, you may contact LifeCare's Privacy Officer (referenced on the last page of this Notice) to obtain the appropriate request form. LifeCare will only accommodate reasonable requests and may require information as to how payment, if any, will be handled.

Do I have the right to inspect and copy my Protected Health Information?

Yes, subject to certain limitations. You have the right to request and obtain access to inspect and copy your Protected Health Information maintained by LifeCare unless the information is (i) psychotherapy notes; or (ii) not required to be accessible under the HIPAA Privacy Rules or other applicable law. For example, you do not have a right to access information compiled by LifeCare in anticipation of, or for use in, a civil, criminal or administrative proceeding. In addition, LifeCare may deny your request to inspect and copy in certain limited circumstances.

LifeCare may charge you a reasonable, cost-based fee for copying (including the cost of supplies and labor) any Protected Health Information required to be copied to adequately respond to your access request, as well as any postage costs and costs associated with preparing an explanation or summary of the Protected Health Information necessary to adequately respond to your access request (unless otherwise precluded by applicable State or other law). If you would like to request access to your Protected Health Information, please notify LifeCare's Privacy Officer (referenced on the last page of this Notice) so that you can complete the appropriate forms.

Do I have the right to request an amendment to my Protected Health Information?

Yes. You have the right to request that LifeCare amend your Protected Health Information. LifeCare reserves the right to deny or partially deny requests for amendments that are not required to be granted under the HIPAA Privacy Rules. For example, LifeCare may deny a request for amendment when the Protected Health Information at issue is accurate and complete. If you would like to request an amendment of your Protected Health Information, please notify LifeCare's Privacy Officer (referenced on the last page of this Notice) so that you can complete the appropriate forms.

Do I have the right to an accounting of disclosures of my Protected Health Information made by LifeCare?

Yes. You have the right to request and obtain a proper accounting of disclosures LifeCare has made of your Protected Health Information in the six years prior to the date on which the accounting is requested. Your request should indicate in what form you want the list (e.g., on paper or electronically). LifeCare is not required, however, to account for all uses and disclosures of Protected Health Information that LifeCare makes. For example, LifeCare is not required to provide an accounting for disclosures made for treatment, payment, or health care operations purposes or for disclosures made with your Authorization. Additionally, LifeCare reserves the right to limit its accountings to disclosures made after the compliance date of the HIPAA Privacy Rules.

LifeCare will provide you with your first accounting at no charge to you. If you request any additional accountings within a 12-month period, LifeCare may charge you a reasonable, cost-based fee. At the time that you request a subsequent accounting, LifeCare will provide you with information regarding the fees, and you will have the opportunity to withdraw or modify your request if you wish to do so. If you would like to request an accounting of your Protected Health Information, please notify LifeCare's Privacy Officer at the current facility.

You Have the Right to Receive this Notice.

You have a right to receive a paper copy of this Notice and/or and electronic copy by email upon request. Please contact LifeCare's HIPAA Privacy Officer at this facility.

How to Complain About Our Privacy Practices?

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue SW, Washington D.C., 20201 or call 1(800) 368-1019. No retaliatory action will be taken against you if you make such complaints.

Contact Person for Information or to Submit a Complaint.

If you have questions about this Notice or any complaints about our privacy practices, please contact LifeCare's HIPAA Privacy Officer at this facility.

Effective Date: This notice is effective on April 14, 2003.

Acknowledgment:

I, the undersigned, acknowledge that I have received, read, and understand this Notice of Privacy Practices of LifeCare.

Signature: ______________________________

Print Name: ______________________________

Date: ______________________________

Affix Patient ID Label Here

NEW PATIENT INTAKE

Patient Number: ________________________ Gender: Male Female

First Name: ______________________________ Middle Initial: _______ Last Name: ______________________________

SS#____ Date of Birth: ____

Admit Date: _________/__________/___________ Status: □ Active □ Consult

New to Hospital: Yes No Referring Physician: _____________________________________

How did the patient hear about the LifeCare Wound Center – Circle the one (primary) that led patient here.

2. Physician
   - i. Podiatrist
   - ii. Family
   - iii. Surgeon
   - iv. Other, ___________

1. Advertising
   - i. Radio/TV
   - ii. Billboard/Newspaper
   - iii. Internet
   - iv. Signage
   - v. Other, ___________

3. Home Health
4. Case Manager
5. Long Term Care
6. Other clinician
7. Other patient
8. Event Speaker
9. Brochure

Reason for Referral: _____Wound Care _____HBOT _____Other

PATIENT SCHEDULED ON: ________________________________ TIME: ________________________

Insurance Information Medicare Part B Eligible? Yes No

Insurance Carrier 1________________________ Policy #____________________ Precert Reqd? Yes No

Subscriber______________________________________ Relationship to patient_____________________

Insurance Carrier 2________________________ Policy #____________________ Precert Reqd? Yes No

Subscriber______________________________________ Relationship to patient_____________________

Subscriber SS#_______________________________ Subscriber DOB_______________________________

Identification Information

Ethnicity: □African American □Asian/Pacific Islander □Caucasian □Hispanic □Native American □Other □Unknown

Address1_____________________________________ Address2_____________________________________

City____State____________Zip_______________________

Phone____Phone_______________________________________

Preferred Language if not English: ____

Care Providers Patient capable of self-care? Yes No

Pharmacy____ Is this a nursing facility referral? Yes No

Pharmacy Phone #_________________________________ Caregiver: Yes No

Caregiver Name___________________________________ Caregiver Phone #_________________________

Home Health Company______________________________ Home Health Nurse________________________

Home Health Phone________________________________ Home Health Fax__________________________

Transportation: ______Private Care ______NETI ______Ambulance ______Other

Who is accompanying patient? ____

PATIENT HEALTH HISTORY

Please fill in as completely as possible.

Name: ____Age:______________
Emergency Contact Person: ________________ Phone number: _______________
Relationship to you: _______Person filling out form (if other than patient):_________
Do you have reliable transportation to therapy? ______________________________
Primary Care Physician (Family Doctor): ______________ Phone: _____________

MEDICAL HISTORY:

Check major **significant illnesses** which apply to you:

__Allergies to drugs
__ CancerType?________
__Chicken Pox

__ Measles
__ Mono
__ Mumps

__Skin rash or eczema

__Allergies/Hay Fever
__Ear abnormalities
__Eye injuries or defects
__Glaucoma or cataracts

__Hearing difficulties
__Sinus Problems
__Vision difficulties

__Asthma
__Frequent or chronic cough
__Lung Disease

__Shortness of breath
__Tuberculosis

__ Chest pain or pressure
__ Dizziness or fainting spells
__Heart Attack
__ Heart Disease

__ Heart Murmur
__High Blood Pressure
__ High Cholesterol
__ Palpitations or pounding heart

__Colon or bowel Disease
__Digestive Disorder
__Gallbladder Problems
__Hernia

__Recurring abdominal pain
__Reflux
__Stomach Problems
__Ulcers

__Arthritis
__ Foot Problems

__Gout
__Neck/back injury

Affix Patient ID Label Here

__ Depression
__ Nervous Disorder/Anxiety
__ Numbness Tingling
__Diabetes
__ Kidney or Bladder problems

__Paralysis
__ Schizophrenia

__Liver Disease/Hepatitis
__Thyroid Problems

__Epilepsy/Seizures
__ Frequent or Severe Headaches
__Aneurysm

__Head Injury
__Stroke

__Anemia
__ Bleeding Disorder
__ Blood Clots

__Varicose Veins
__Vascular Disease

SURGICAL HISTORY:

List the year of any **operations/procedures** you have had (if year unknown use check mark):

__Appendectomy
__Back surgery
__Breast biopsy
__Bypass, heart surgery
__Carotid endarterectomy
__Carpal tunnel
__Cataract
__Cesarean section
__Colonoscopy

__D&C
__Gallbladder
__Hemorrhoids
__Hernia
__Hip replacement
__Hysterectomy
__Knee surgery
__Mastectomy
__Vascular surgery

__Nasal/sinus surgery
__Prostate surgery/biopsy
__Splenectomy
__Thyroid surgery/ablation
__Tonsils/adenoids removed
__TURP
__Tubal ligation
__Vasectomy
__Amputations

__Implanted devices (i.e. surgical placement of a pump, pacemaker, port or stent)
__Others: ____________________
List any trauma/broken bones/serious accidents including year:______________________.
List any major hospitalizations: ____.
Have you been hospitalized in the last 30 days? ____If yes, why? ____________________.
What other doctors have you seen? ____.

Medications: list and describe reaction: ____
__Food __Animals __Latex __Tape __Pollens __Iodine Others: _______________

Affix Patient ID Label Here

MEDICATIONS:

List **all medications** you are currently taking which have been ordered by a doctor (including inhaler) and then list **all over the counter drugs**, vitamins and herbs.
Name of medication/dose/frequency:

1.______________	7.______________	13.______________
2.______________	8.______________	14.______________
3.______________	9.______________	15.______________
4.______________	10.______________	16.______________
5.______________	11.______________	17.______________
6.______________	12.______________	18.______________

FAMILY HISTORY:

1. Are you adopted? __yes __no
2. List the cause of death for any family member who has died prior to age 50:____
3. Check any illnesses which have occurred in a blood related family member:

brother (b), sister (s), mother (m), father (f) or grandparent (g):

Alcoholism/Substance abuse_________	Emotional/Suicide_____________
Alzheimer's/Dementia__________	High Blood Pressure__________
Cancer (breast)__________	Heart Attack prior to age 55__________
Cancer (colon)__________	Osteoporosis__________
Cancer (prostate)__________	Stroke__________
Cancer (other)__________	Tuberculosis__________
Diabetes__________	Thyroid disease_________

Others____

SOCIAL HISTORY:

1. **On average** how many alcoholic drinks (1 drink =12 oz beer, 10 oz wine cooler, 5 oz wine, 1.5 oz liquor) do you consume in one week?
   __nondrinker __1-5 __6-10 __11-15 __15-20 __>20
   A. Have you ever thought you had a problem with drinking? __yes __no
2. What is your tobacco use status? __never __past __current
   a. Indicate type: __cigarettes __cigar __pipe __snuff __chew
   b. Number of years used: ___
   c. Average packs (cans, etc) used/day: ____
   d. Year quit:___
   e. Would you like help quitting? __yes __no
3. Marital Status: __Married __Single __Widowed __Divorced __Separated
   __Living with significant other
4. Occupation: ______________________

Affix Patient ID Label Here

5. Please give history of current or previous drug use (other than prescriptions):____
6. List your ethnic origin:
   __White __Hispanic __African/American __Asian __Other:______________

REVIEW OF SYSTEMS:

Check any condition(s) which are SIGNIFICANT PROBLEMS to you:

General:
- ❑ Loss of appetite
- ❑ Major weight gain or loss
- ❑ Fever (frequent)
- ❑ Night sweats
- ❑ Undergoing chemotherapy

Eyes:
- ❑ Blind
- ❑ Glasses
- ❑ Contacts

Mouth:
- ❑ Dentures Upper or Lower
- ❑ Partials Upper or Lower

Head and Neck:
- ❑ Loss of hearing
- ❑ Deaf
- ❑ Hearing Aids
- ❑ Cataracts
- ❑ Ringing in ears
- ❑ Frequent ear infections
- ❑ Frequent persistent nose bleeds
- ❑ Allergies
- ❑ Sinus problems

Heart:
- ❑ History of murmur
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Chest pain
- ❑ Ankle swelling

Respiratory:
- ❑ Chronic cough
- ❑ Shortness of breath
- ❑ Coughing up blood
- ❑ Wheezing
- ❑ Stop breathing during sleep
- ❑ Collapsed lung

Stomach:
- ❑ Black or bloody stools
- ❑ Abdominal pain
- ❑ Chronic frequent nausea/vomiting
- ❑ Frequent heartburn/acid in throat
- ❑ Chronic diarrhea

Skin/Hair:
- ❑ Wounds that will not heal
- ❑ Persistent rash
- ❑ Major skin disorder

Skeletal:
- ❑ Joint pain (major)
- ❑ Joint swelling or stiffness
- ❑ Decreased range of motion
- ❑ Joint deformity or scoliosis
- ❑ Back pain (major)
- ❑ Neck pain (major)
- ❑ Amputation
- ❑ Prosthesis
- ❑ Pain in calf with walking

Neurological:
- ❑ Fainting
- ❑ Seizures
- ❑ Weakness of extremity
- ❑ Numbness or tingling
- ❑ Severe frequent headaches

Psychiatric:
- ❑ Feeling blue/discouraged
- ❑ Feeling anxious/nervous
- ❑ Claustrophobia

Reproduction:
- ❑ Inability to have an erection
- ❑ Are you pregnant

Kidney/bladder:
- ❑ Chronic kidney/bladder infections
- ❑ Problem with bladder control
- ❑ Burning or painful urination
- ❑ Blood in urine

Affix Patient ID Label Here

Hill Wound Care Management Appointment Policy

Outpatient Wound Care & HBO Center

Hill Wound Care management patients are expected to make their scheduled appointments. In the event patients are unable to make their appointments, they are expected to cancel 24 hours in advance outside of emergencies. If appointments are not cancelled within 24 hours and there is not an emergency, patient will be billed $25 for a missed visit. If patients are more than 15 minutes late for scheduled appointments, they will need to be rescheduled. This will be considered a missed appointment and a fee will apply unless an emergency has occurred.

I have read and agree to the above policy with Hill Wound Care Management.

______________________________ _______________

Patient Signature Date

Affix Patient ID Label Here

Agreement Between Patient and Provider

Date: _________

I understand that I am being seen for wound care treatment to assist healing of my wound(S). I understand the treatment is known to be effective only when provided on a regular basis. Lapses in treatment, such as missing my appointments, and failure to comply with the plan of care can result in therapy becoming less effective and ineffective. Thus, I understand that for my treatment to be worthwhile, it is important that I receive treatment as scheduled and follow the Plan of Care that I have been educated on.

I agree to the following conditions by initial:

______ I will appear for treatment as scheduled. (If I am unable to appear for a scheduled appointment, I will notify the WCC staff at least 24 hours in advance. I will also make every arrangement to get the appointment for the same day and/or next day during regular business hours).

______ I will follow the treatment plan instructions provided to me and I will actively seek assistance when I find myself unable to comply with the Plan of Care. I agree to notify the WCC staff immediately if I have any problems, questions, or concerns regarding my wound and how I should care for it.

______ I understand that a violation of any of these conditions may result in my discharge from the WCC's program.

______ I agree to be an active participant in my care.

Patient Name/Signature: ______________________________ Date: ____________

Provider Name/Signature: ______________________________ Date: ____________

Affix Patient ID Label Here

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and any treatments that may be recommended, so that you may make the decision whether or not to undergo the procedure after knowing the associated risks, benefits, and alternatives. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed, so you may give or withhold your consent to the procedure.

Patient Name: ______________________________ Hospital: ______________________

It has been explained to me by my physician, Dr. ________________________, that I need to have the procedure: **Excisional Debridement of Wound(s) with or without (circle one) Moderate Sedation** on the following site or sites: ____________ ______________________________ done during my hospitalization. This consent covers the first and subsequent debridement procedures on the same wound(s). Any new wounds require a separate consent.

The purpose and the procedure have been explained to me, and I understand that it is performed to remove dead or diseased tissue from my wound so that new healing may be allowed to occur.

I understand it is a common procedure which usually occurs without complication; however, I have been informed that there are possible risks involved which are usually treatable, but may rarely be life-threatening. I also understand that the use of conscious moderate sedation to keep me calm comfortable during the procedure may be used during this procedure and may have additional risks. These risks include, but are not limited to the following:

> Risks for Excisional Debridement include but are not limited to: pain or tenderness, bleeding, infection, scarring, a larger wound bed for a period of time.
>
> Risks for Moderate Sedation depends on the medication used, but may include: allergic reactions, irregular heart rhythms, respiratory depression, low blood pressure, irritation at the IV site, confusion, anxiety, drowsiness, memory dysfunction or loss, and rarely permanent organ damage, brain damage, or the medical necessity to convert to general anesthesia.

The alternatives to this procedure, and the risks and consequences of those alternatives have been explained to me, including the use of non-excisional debridement wound products, delaying this procedure or refusing this procedure, any of which may result in a delay in healing or a worsening of my symptoms or disease. I understand and acknowledge these alternatives.

I voluntarily authorize my attending physician, or consulting physician, their associates or assistants, and the hospital staff working at their direction, to proceed with this procedure. I have been given an opportunity to ask questions about my condition, this procedure, its risks, benefits, alternatives, and the risks and benefits of the alternatives, including the risk of non-treatment. I have sufficient information to give this informed consent. I acknowledge that no guarantees or assurances have been made to me in connection with this procedure, and I assume the risks. I understand that the practice of medicine is not an exact science. I understand that I may withdraw my consent and discontinue participation in this treatment at any time.

DISCLOSURE AND CONSENT

I certify that this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents. I am satisfied with the explanations, and my CONSENT hereby is given voluntarily. I also represent that I am competent to act on my own behalf, and am acting voluntarily.

______________________________ Date: __________ Time: __________
Patient Signature or Signature of Legally Responsible Person/Relationship to Patient

______________________________ Date: __________ Time: __________
Patient Printed Name or Printed Name of Legally Responsible Person/Relationship to Patient

Telephone Consent Given By: ______________________ Date: __________ Time: __________
Name/Relationship to Patient

Witness to ☐ Signature ☐ Telephone Consent ***(requires 2 witnesses)*** ______________________
Printed Name/Signature

Witness to ☐ Signature ☐ Telephone Consent ***(requires 2 witnesses)*** ______________________
Printed Name/Signature

I have explained the matters indicated above relating to the procedure(s), consequences, and alternatives.
The patient and/or the legally responsible person indicated understanding and consented to the procedures described above.

Date: __________ Time: __________ **Physician Signature:** ______________________

Date: __________ Time: __________ **Physician Printed Name:** ______________________

CONSENT FOR EXCISIONAL DEBRIDEMENT OF WOUND

284

LABEL / ADDRESSOGRAPH