US Wound Care & Hyperbaric Centers

New Patient Forms

Patient Name	
Patient DOB	
Patient Address	
Patient Phone Number(s) *list all that apply*	
Patient E-mail	
Emergency Contact Name/Number	
Insurance Company & Policy Holder Name	
Policy Holder SSN & Patient SSN	

MEDICATIONS: ***Please list all prescription and non-prescription medications***

MEDCIATION	DOSE	FREQUENCY

ALLERGIES: ***Please list all allergies and reactions to medications, food, etc.***

ALLERGY	REACTION

PAST MEDICAL HISTORY: ***Please check all that apply.***

- ☐ MRSA/VRE
- ☐ Damage to eardrums
- ☐ Sinusitis
- ☐ Ringing in ears
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Damage to retina
- ☐ Asthma
- ☐ COPD
- ☐ Collapsed lung
- ☐ Oxygen dependence
- ☐ Congestive heart failure (CHF)
- ☐ Coronary artery disease
- ☐ Heart attack
- ☐ DVT or PE
- ☐ Hypertension
- ☐ Peripheral vascular disease
- ☐ High cholesterol
- ☐ Cirrhosis of the liver
- ☐ Hepatitis
- ☐ Crohn's disease
- ☐ Ulcerative colitis
- ☐ GERD
- ☐ Chronic kidney disease
- ☐ End-stage renal disease
- ☐ Dialysis (Type: _____)
- ☐ Diabetes (Type: _____)
- ☐ Amputation
- ☐ Osteoarthritis
- ☐ Gout
- ☐ Paraplegia
- ☐ Quadriplegia
- ☐ Osteomyelitis (bone infection)
- ☐ Burn
- ☐ Scleroderma
- ☐ Cancer (Type: _____)
- ☐ Seizure disorder
- ☐ Stroke
- ☐ Dementia/ Alzheimer's
- ☐ Depression
- ☐ Anemia
- ☐ Sickle Cell Disease
- ☐ Lymphedema
- ☐ AIDS/HIV
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Rheumatoid Arthritis
- ☐ Reynaud's
- ☐ Previous Wound(s) Location: _____
- ☐ Other: _____ _____

US Wound Care & Hyperbaric Centers

Patient Name: _____

SURGICAL HISTORY: ***Please list all surgeries and the corresponding month/year performed.***

SURGERY	MONTH	YEAR

REVIEW OF SYSTEMS: ***Please check all that apply.***

Constitutional
- ☐ Fevers
- ☐ Chills
- ☐ Fatigue
- ☐ Marked weight change
- ☐ Loss of appetite
- ☐ Night sweats

Eyes
- ☐ Glasses/contacts
- ☐ Vision changes

Ear/Nose/Mouth/Throat
- ☐ Difficulty clearing ears
- ☐ Dental problems
- ☐ Hearing loss/aid
- ☐ Nasal congestion
- ☐ Painful/swollen lymph nodes
- ☐ Ear pain

Respiratory
- ☐ Cough
- ☐ Shortness of breath
- ☐ Oxygen use
- ☐ Wheezing

Cardiovascular
- ☐ Chest pain
- ☐ Dyspnea on exertion
- ☐ Intermittent claudication
- ☐ Leg resting pain
- ☐ Leg swelling
- ☐ Palpitations
- ☐ Orthopnea

Gastrointestinal
- ☐ Nausea/Vomiting/ Diarrhea
- ☐ Stomach pain
- ☐ Acid reflux
- ☐ Bowel Incontinence

Integumentary
- ☐ Changes in hair/skin/nails
- ☐ Calluses/corns
- ☐ Hyperpigmentation
- ☐ Ulcers
- ☐ Prone to skin tears
- ☐ Rash
- ☐ Abnormal hair growth
- ☐ Dryness
- ☐ Itching

Musculoskeletal
- ☐ Assistive devices
- ☐ Decreased activity
- ☐ Joint pain
- ☐ Deformities
- ☐ Weakness

Neurological
- ☐ Abnormal gait
- ☐ Numbness
- ☐ Pain from neuropathy
- ☐ Paralysis
- ☐ Seizures
- ☐ Fainting
- ☐ Memory loss
- ☐ Loss of coordination

Hematologic/Lymphatic
- ☐ Bruising
- ☐ Bleeding

Allergic/Immunologic
- ☐ Frequent rashes
- ☐ Recurrent fevers
- ☐ Sensitivity to drugs
- ☐ Sensitivity to food
- ☐ Hay fever

Psychiatric
- ☐ Anxiety
- ☐ Claustrophobia
- ☐ Depression
- ☐ Suicidal
- ☐ Mental illness

Endocrine
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst
- ☐ Excessive urination

Genitourinary
- ☐ Blood in urine
- ☐ Frequency
- ☐ Urgency
- ☐ Urinary incontinence
- ☐ Painful urination

US Wound Care & Hyperbaric Centers

Patient Name: _____

PHARMACY & OTHER PHYSICIANS: ***Please note your preferred pharmacy. Also, please list any of your other doctors or home health agency in the event we need to contact them for records or refer you out for adjunct healthcare services***

PHARMACY	STREET ADDRESS	PHONE NUMBER

PHYSICIAN/HOME HEALTH AGENCY	SPECIALTY	PHONE NUMBER

FAMILY HISTORY: ***Please check all that apply***

CONDITION	MOTHER	MATERNAL GRAND-PARENTS	FATHER	PATERNAL GRAND-PARENTS	SIBLING	CHILD	NO HISTORY	NOTES
UNKNOWN HISTORY								
NON-CONTRIBUTORY								
AUTOIMMUNE DISEASE								
CANCER								
DIABETES								
HEART DISEASE								
HYPERTENSION								
KIDNEY DISEASE								
LUNG DISEASE								
SEIZURES								
STROKE								

SOCIAL STATUS/HISTORY: ***Please check all that apply***

- ☐ Tobacco use
- ☐ Alcohol use
- ☐ Substance abuse
- ☐ Caffeine use
- ☐ Occupation: _____
- ☐ Retired
- ☐ Married
- ☐ Children
- ☐ Cultural/religious/ language concerns: _____
- ☐ Financial concerns
- ☐ Transportation concerns
- ☐ Independent
- ☐ Support systems lacking
- ☐ Unable to care for self
- ☐ Lives with: _____
- ☐ Lives alone
- ☐ Home care
- ☐ Assisted living
- ☐ Long term care facility
- ☐ Skilled nursing facility
- ☐ Signs/symptoms of abuse/neglect
- ☐ Suicide risk: patient denies suicidal ideation
- ☐ Suicide risk: patient has thoughts of self-harm
- ☐ Suicide risk: patient confirmed having plan to self-harm
- ☐ Suicide risk: patient has attempted self-harm/suicide in the past year

US Wound Care & Hyperbaric Centers

Patient Name: _____

RIGHTS & RESPONSIBILITIES

Welcome to Northwest Florida Wound Care & Hyperbaric Center, LLC a part of US Wound Care and Hyperbaric Centers. We are glad to have you as a patient, and we will strive to provide you with the highest quality patient care.

In order to do this, we will make the following commitments to you:

- The staff will treat you as promptly as possible at your scheduled appointment time.
- We will be considerate and compassionate.
- We will try to meet your goals as a patient, as directed by your physician.
- We will schedule your appointments in advance, within our scheduling confines, and will try to make those appointments as convenient as possible for you.

In order to provide quality service to all our patients, we make the following requests:

- If you are unable to make your scheduled appointment, please call us at 1-855-WOUND01, at least 24 hours prior to your scheduled appointment.
- Please call if you know you will be more than 10 minutes late and we will do our best to accommodate you.
- If you are more than 15 minutes late for your appointment, without calling, your appointment will be forfeited.
- If you miss 3 appointments without calling to cancel or reschedule, any future appointments you have scheduled will be cancelled and you will be discharged.

It is our goal to provide high quality services in a friendly, professional, kind environment; any behavior detrimental to this environment may be grounds for dismissal from the clinic. Please refer to our Attendance Policy for additional information.

What to expect: To begin care, we do require a consult with our physician. Depending on your insurance requirements, this may also entail obtaining a referral from your referring physician. Please be advised that we are obligated to treat you for the reason you were referred here and cannot provide any treatment not authorized by your physician, prescribe any medications, or offer any diagnoses outside the scope of this specialist's office. Prescriptions are valid only 30 days from the date they were issued. We will forward progress notes to your physician upon evaluation, periodically during treatment, and at discharge.

As stated in the consent depending on your insurance, you may have some financial obligations for your treatment such as a copayment per visit or percentage of total cost. Based on verification from your insurance company, an estimate of your financial responsibility is: $_____per visit /_____%.

In order to receive the maximum benefits, we recommend you wear comfortable clothing and shoes, follow your home program, and maintain as close as possible the schedule of appointments recommended by your physician. If you have any additional questions, please feel free to ask any member of the staff.

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.

Patient Name: _____

- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to bring any person of his or her choosing to the patient-accessible areas of the health care facility or provider's office to accompany the patient while the patient is receiving inpatient or outpatient treatment or is consulting with his or her health care provider, unless doing so would risk the safety or health of the patient, other patients, or staff of the facility or office or cannot be reasonably accommodated by the facility or provider.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, or handicap.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

US Wound Care & Hyperbaric Centers

Patient Name: _____

TREATMENT & CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about 1) your condition; 2) the recommended surgical, medical, or diagnostic procedure to be used; and 3) the risks and hazards relating to this care/procedure. This disclosure is designed to provide you this information, so that you can decide whether to consent to receive this care/procedure. Please ask your physician/healthcare provider any remaining questions you have before signing this form.

Description of Medical Care and Surgical Procedure(s)

_____ **(Initial)** I (we) voluntarily request **Dr.** _____ as my physician, and such associates as he/she may deem necessary (for example, educational assistants and other health care providers who are identified, and their professional role explained to me) to treat my condition. My condition has been explained to me as:

(Condition to be treated) _____

_____ **(Initial)** I (we) understand that the following potential surgical, medical and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedure(s). **Potential procedures:** excisional and/or selective debridement of wound(s), (removing dead tissue). This consent covers all excisional and/or selective debridement(s) for the patient's entire episode of care. I (we) understand that these qualified medical practitioners may be performing significant tasks related to the surgery such as opening or closing incisions, harvesting or dissecting tissue, altering tissue, implanting devices, tissue removal or photography during procedures.

Potential for Additional Necessary Care/Procedure(s)

_____ **(Initial)** I (we) understand that my physician may discover other or different conditions which require additional procedures than those planned. I (we) authorize my physician, and any associates, technical assistants and other health care providers to perform such other procedures which are advisable in their professional judgement.

Risk Related to this Care/Procedure

_____ **(Initial)** Just as there may be risk and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical and/or diagnostic procedures planned for me, such as the potential for infection, blood clots in veins and lungs, hemorrhage (severe bleeding), allergic reactions and even death. I (we) also realize that the following specific risks and hazards may occur in connection with this particular procedure(s): (1) Bleeding (2) Pain (3) Loss of limb (4) Adverse drug reaction (5) Lack of wound healing (6) Infection and/or (7) Additional Surgery. The chances of these occurring may be different for each patient based on the care/procedure and the patient's current health.

Granting of Consent for this Care/Procedure(s)

_____ **(Initial)** I (we) have been given the opportunity to ask questions about my current condition(s), the proposed procedure(s) and steps that will occur during my care/procedures, the benefits, the likelihood of success, the possible risks and hazards involved in the care/procedure and possible problems related to recovery, the possible risks of nontreatment of my condition, and other alternative forms of treatment, and the risks and benefits of alternatives involved. I (we) understand that no warranty or guarantee has been made to me as to result or cure. Any professional/business relationships between my health care providers, the hospital and educational institutes has been explained to me.

_____ **(Initial)** I (we) certify this form has been fully explained to me, that I (we) have read it or have had it read to me (us), that the blanks spaces have been filled in, and that I (we) understand contents. I (we) believe that I (we) have enough information to give this informed consent and I (we) request the procedure(s) to be done.

US Wound Care & Hyperbaric Centers

Patient Name: _____

Indemnity Clause. **I am fully aware that there are inherent risks involved with this procedure as described in this form and I choose to undergo the described procedure with full knowledge of the potential risks. I agree to indemnify and hold harmless Northwest Florida Wound Care & Hyperbaric Center, LLC, its owners, affiliates, managers, contracted physicians, employees, agents and representatives ("Indemnitees") from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, that may occur as a result of any failure of my implanted device while I am undergoing hyperbaric treatment.**

_____ _____

Patient/Other Legally Authorized Representative Signature **Date**

If Legally Authorized Representative, list relationship to Patient: _____

_____ (Printed Name)

Statement by Physician

I have provided the patient/parent/guardian with information on risks, benefits and alternatives to wound care and hyperbaric treatment as outlined in the above within my area of expertise.

_____ _____

Physician Signature **Date**

_____ (Printed Name)

_____ _____

Witness Signature **Date**

_____ (Printed Name)

US Wound Care & Hyperbaric Centers

Patient Name: _____

ADDITIONAL CONSENT FOR TREATMENT, PAYMENT, PATIENT RESPONSIBILITY, AND COMMUNICATION

_____ **(Initial)** Consent for Treatment and Payment Agreement: I consent to Northwest Florida Wound Care & Hyperbaric Center, LLC's administration and performance of wound care treatment, use of prescribed medications, performance of diagnostic procedures, test and cultures and performance of other laboratory test that the physician or designee determines medically necessary or advisable based on the judgement of my physician or their assigned designees. I give consent in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. Consent will remain in force until revoked in writing; and a revocation of this consent will not affect the validity of my consent as to acts performed prior to the revocation. A photocopy of this consent shall be as valid as the original. I understand that while my consent is voluntary, if I refuse to sign this consent, Northwest Florida Wound Care & Hyperbaric Center, LLC may refuse to treat me or my minor/disabled patient. If I am signing this consent on behalf of a patient who is under age 18 or impaired in such a way as to make him or her unable to consent to or refuse treatment, I represent to Northwest Florida Wound Care & Hyperbaric Center, LLC that I have legal authority to consent to treatment on the patient's behalf and that I do in fact consent to treatment as described in the preceding paragraph, In such a case, references in this form to "I", "me", or "my" are intended as references to the patient where appropriate in the context of:

_____ **(Initial)** Patient Responsibility for Follow-Up: I understand that it is my responsibility to follow any discharge and/or follow-up instructions that Northwest Florida Wound Care & Hyperbaric Center, LLC may provide to me, including without limitation any recommended home-care and any follow-up examination and/or treatment by other healthcare providers. I accept full responsibility for the consequences of any failure by me to obtain recommended follow-up care and/or to comply with any other discharge instructions related to this clinic's visit.

_____ **(Initial)** Responsibility for Payment: In consideration of the services Northwest Florida Wound Care & Hyperbaric Center, LLC will provide to me, I promise to pay Northwest Florida Wound Care & Hyperbaric Center, LLC charges for services. I understand Northwest Florida Wound Care & Hyperbaric Center, LLC may file its bill with my insurance company, but I understand that it is my responsibility to obtain any referral forms from my primary care physician that my insurance company may require as a condition to its payment for my healthcare service. I understand that the cost of healthcare services provided to me is my personal responsibility, even if I have insurance coverage for that cost, and that I am directly liable to Northwest Florida Wound Care & Hyperbaric Center, LLC for any portion of such cost that my insurance company or other third-party payer does not pay, for any reason. If I am signing this form on behalf of a person whom I have allowed to be a dependent on my insurance coverage, I acknowledge that I am personally liable for any co-payment, deductible obligation, or other portion of Northwest Florida Wound Care & Hyperbaric Center, LLC for services to that person that my insurance company or other third-party payer does not pay. If that patient is my minor child, I acknowledge that I am legally responsible to Northwest Florida Wound Care & Hyperbaric Center, LLC for its charge for services to the patient without regard to the allocation of liability for such charges as between other persons and me in a decree of divorce or other court order or decree. I understand that if my account with Northwest Florida Wound Care & Hyperbaric Center, LLC is unpaid for more than a reasonable amount of time, Northwest Florida Wound Care & Hyperbaric Center, LLC will place my account with a collection agency, and, if necessary, cause my unpaid account to appear on my credit report. I agree to endorse and forward Northwest Florida Wound Care & Hyperbaric Center, LLC all insurance or third-party payments that I receive for services Northwest Florida Wound Care & Hyperbaric Center, LLC has rendered to me, immediately upon my receipt of such payment.

_____ **(Initial)** Medical Records: I understand that Northwest Florida Wound Care & Hyperbaric Center, LLC maintains medical records in the office which will be used on an ongoing basis for planning care and treatment. Information within the medical record may be released by Northwest Florida Wound Care & Hyperbaric Center, LLC to my other physicians/healthcare providers and insurance company as necessary for billing and medical reasons. I authorize Northwest Florida Wound Care & Hyperbaric Center, LLC to access by prescription history from external sources. MEDICARE PATIENTS: I authorize Northwest Florida Wound Care & Hyperbaric Center, LLC to release my medical information to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Northwest Florida Wound Care & Hyperbaric Center, LLC.

_____ **(Initial)** E-mail: If I have provided my email address on this form, I understand that Northwest Florida Wound Care & Hyperbaric Center, LLC will keep that address confidential and will not rent or sell it. I understand Northwest Florida Wound Care & Hyperbaric Center, LLC has requested my email address in case Northwest Florida Wound Care & Hyperbaric Center, LLC needs to contact me. I consent to Northwest Florida Wound Care & Hyperbaric Center, LLC sending me, as a courtesy, patient follow-up communications, satisfaction surveys, or urgent notices.

_____ **(Initial)** Consent to Wireless Telephone Calls: I consent to receive telephone calls, SMS text, and other communications on my cellular phone, other phone(s), and other communication devices, including autodialed calls and prerecorded messages from Northwest Florida Wound Care & Hyperbaric Center, LLC, its successors, assigns, affiliates, agents, independent contractors, servicers, and collection agents. I understand these calls may regard my visit to Northwest Florida Wound Care & Hyperbaric Center, LLC or financial obligations related to my visit.

_____ **(Initial)** I acknowledge that I have received or been given the opportunity to receive a copy of Northwest Florida Wound Care & Hyperbaric Center, LLC HIPAA Privacy Policy and understand that if I have any questions or complaints, I should contact the Northwest Florida Wound Care & Hyperbaric Center, LLC PLLC Privacy Officer at 1-855-WOUND01.

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

US Wound Care & Hyperbaric Centers

Patient Name: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last **First** **Middle**

OTHER NAME(S) USED_____

DATE OF BIRTH: Month_____ **Day**_____ **Year**_____

ADDRESS_____

City **State** **Zip Code**

PHONE (____) _____ **ALT. PHONE** (___) _____**EMAIL ADDRESS (Optional):** _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Northwest Florida Wound Care & Hyperbaric Center, LLC
11501 Hutchison Blvd., Ste. 109
Panama City Beach, Florida 32407
(850) 250-0721

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____

Address _____

City **State** **Zip Code**

Phone (___) _____ Fax (___) _____

REASON FOR DISCLOSURE:

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other

US Wound Care & Hyperbaric Centers

Patient Name: _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date: Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

RIGHT TO RECEIVE COPY: I understand that I have the right to receive a copy of this authorization.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Florida Statutes Annotated § 456.057 and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____ _____

Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship wo the individual: ☐ Parent of a minor ☐ Guardian ☐ Other _____

US Wound Care & Hyperbaric Centers

Patient Name: _____

Medical and Surgical Procedures

TO THE PATIENT: You have the right to be informed about 1) your condition, 2) the recommended medical care or surgical procedure, and 3) the risks related to this care/procedure. This disclosure is designed to provide you this information, so that you can decide whether to consent to receive this care/procedure. Please ask your physician/health care provider any remaining questions you have before signing this form.

Description of Medical Care and Surgical Procedure(s)

I, _____[patient name] voluntarily request my physician/provider __**Leonard Fichter, DO**_____ [name/credentials], and other health care providers/entities, specifically **US Wound Care & Hyperbaric Centers (also known as Northwest Florida Wound Care & Hyperbaric Center)**, to treat my condition which is:

_____

I understand that the following care/procedure(s) or a combination of procedures/treatments may be required, including but not limited to wound management, care and treatment, debridements, wound cleansing, application of dressings, other wound management interventions as appropriate and necessary, biopsies, application of compression wraps or Unna boots, application of total contact cast, application of negative pressure wound therapy devices, other advanced wound management interventions and/or device applications, application of cellular tissue products/skin substitute applications, and any other procedures/interventions/medications/devices as deemed necessary by the physician/provider. I (we) understand that this consent is continuing in nature and remains in effect for any additional, repeat or subsequent procedures/treatments that may be needed on an ongoing basis or during this admission/episode of care. The consent will remain fully effective until it is revoked in writing. You have the right at any time to ask additional questions or to discontinue or decline services.

Potential for Additional Necessary Care/Procedure(s)

I understand that during my care/procedure(s) my physician/health care provider may discover other conditions which require additional or different care/procedure(s) than originally planned.

I authorize my physicians/health care providers to use their professional judgment to perform the additional or different care/procedure(s) they believe are needed.

Risks Related to this Care/Procedure(s)

Just as there may be risks and hazards to my health without treatment, there are also risks and hazards related to the care/procedure(s) planned for me.

I understand that all care/procedure(s) involve some risks, ranging from minor to severe. These risks may include but are not limited to infection, clots in blood vessels, lungs or other organs, bleeding, hemorrhage (severe bleeding), allergic reactions, poor wound healing, development of new wounds or other complications, death, pain related or unrelated to the procedure, loss of tissue/limb, lack of response or inadequate response to treatment, complications from or adverse reaction or a combination of adverse reactions to wound management, care and treatment, debridements, wound cleansing, application of dressings, other wound management interventions, biopsies, application of compression wraps or Unna boots, application of total contact cast, application of negative pressure wound therapy devices, other advanced wound management interventions and/or device applications, application of cellular tissue products/skin substitute applications, and/or any other procedures/interventions/medications/use of devices or any other treatment/therapy performed or administered, lack of response or inadequate response to a procedure or treatment, need for repeat treatments/procedures, other unanticipated, unexpected and/or unforeseen complications.

I (we) understand that no warranty or guarantee, expressed or implied, has been made to me as to the result or cure. The chances of these occurring may be different for each patient based on the care/procedure(s) and the patient's overall health.

US Wound Care & Hyperbaric Centers

Patient Name: _____

Medical and Surgical Procedures

Granting of Consent for this Care/Procedure(s)

In signing below, I consent to the care/procedure(s) described above. I acknowledge the following:

- I understand this care/procedure(s) does not guarantee a result or a cure to my condition.
- I have been given an opportunity to ask questions I may have about:
    1. Alternative forms of treatment,
    2. Risks of non-treatment,
    3. Steps that will occur during my care/procedure(s), and
    4. Risks and hazards involved in the care/procedure(s).
- I believe I have enough information to give this informed consent.
- I certify this form has been fully explained to me and the blank spaces have been filled in.
- I have read this form or had it read to me.
- I understand the information on this form.

If any of those statements are not true for you, please talk to your physician/health care provider before continuing.

Patient/Other Legally Authorized Representative (signature required):

_____ _____

Print Name Signature

If Legally Authorized Representative, list relationship to Patient: _____

Date: _____ Time: _____A.M./P.M.

Witness:

_____ _____

Print Name Signature

_____

Address (Street or P.O. Box)

_____

City, State, Zip Code

Physician:

I have provided the patient/legally responsible person with information about the procedure, its risks, hazards, benefits, the likelihood of achieving goals, alternatives, and risks to alternative therapy, including no therapy. No warranty or guarantee, expressed or implied, was made as to the outcome or result/cure.

_____ _____

Physician Signature Date

US Wound Care & Hyperbaric Centers

Patient Name: _____

PATIENT ATTENDANCE POLICY

At US Wound Care & Hyperbaric Centers, we strive to provide our patients with excellent service and care. Our commitment to your well-being and healing in our wound care and the hyperbaric process is something everyone in our clinic takes quite seriously. We pride ourselves on providing a personalized team approach to your care. To provide this level of service, we reserve set appointment times for *each* individual patient.

We care about you and realize that it would be a disservice if we did not emphasize the importance of your commitment to your own care and well-being. Your adherence to the recommended number of visits and/or treatments is a vital component of your progress with our services. Therefore, we have certain policies in place to ensure the most optimal results.

CANCELLATIONS: Consistent attendance and active participation in your treatment are keys to successful wound healing. Repeated last-minute cancellations imply a lack of commitment to your recovery. Thus, for any reason you must cancel an appointment, our office requires **24-hour advanced notice**. Cancellations within the 24-hour period or missed appointments are subject to a **$25.00 short-notice cancellation/no-show fee**.
NOTE: This cancellation/no-show payment **will be due before your next scheduled appointment. Please note that your insurance does not cover this.**

LATE ARRIVALS: Arriving on time is a critical part of delivering optimal care to our patients. Understandably, arriving late from time to time is an unavoidable part of life. However, chronic late arrivals demonstrate a lack of commitment to your healthcare and recovery. If at any time you are 15 minutes late without coordinating with our front office, we reserve the right to reschedule your visit.

REPEATED NON-COMPLIANCE: Instances of repeated non-compliance with your scheduled visits indicate a lack of commitment to your plan of care. We reserve the right to discontinue care, and we will inform your physician and/or case manager of the fact that your service has been discontinued due to non-compliance with their prescribed order.

I have read and understand the above policies and agree to the obligation of my care.

_____ _____

Patient/guardian signature **Date**

Contact information preferences for scheduling, appointment reminders, or general correspondence

By indicating my preferred method for clinic communications, I am giving consent to utilize the method(s) below to reach me for appointment reminders, scheduling changes, or other general clinic communication.

□ **Phone call** Cell: _____ Home: _____ Work: _____

□ **Text message** Cell: _____

□ **E-mail** Email address: _____

US Wound Care & Hyperbaric Centers

Patient Name: _____

HIPAA CONTACT AND RELEASE

Keeping our patient's information private is important to us, and by default, we will only disclose information related to the patient's billing and medical condition(s) to the patient or legal guardian. If you would like to add additional contacts that US Wound Care & Hyperbaric Centers are allowed to disclose this type of information, please complete the fields.

CONTACT NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER

_____ _____

Signature of patient/legal guardian **Date**

US Wound Care & Hyperbaric Centers

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize US Wound Care & Hyperbaric Centers to release my confidential health information by releasing a copy of my medical records, or a summary or narrative of my protected health information, to a designated physician(s), the person(s), facility/entity, and/or those directly associated with the medical care I will receive at this facility.

_____	_____	_____
Patient/Guardian Signature	**Printed Patient Name**	**Patient DOB**
_____	_____	
Relationship of Guardian	**Date**	

----------STAFF USE ONLY----------

Requesting Physician: _____

Requesting Center Information:

- □ NW Florida Wound Care & Hyperbaric Center:
  11501 Hutchison Blvd, Suite 109
  Panama City Beach, FL
  Phone: (850) 250-0112
  Fax: (850) 250-3589

The information requested for release by the treating physician, subject to this signed medical release, is as follows:

□ Complete Records	□ History & Physical	□ Progress Notes	□ Care Plan
□ Lab Reports	□ Radiology Reports	□ Pathology Reports	□ Treatment Record
□ Operative Reports	□ Hospital Reports	□ Medication Records	□ Vascular Studies

□ Other: _____

The purpose/reason for this record release request is as follows:

_____

_____