

Premier Wound Care, PLLC

Patient Information

First _____ Last _____ MI _____

Date of Birth _____ Gender M / F Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____ Marital Status _____

Language: English Spanish Other Race: Asian Black or African American White Other

Patient Employer _____ Employer's Phone _____

Spouse Name _____ Spouse's DOB _____ Spouse's Phone _____

Emergency Contact _____ Phone _____

Pharmacy _____ City _____

Primary Insurance _____ Secondary Insurance _____

If policy holder of insurance is different than the patient, please complete following:

Policy Holder Name _____ DOB _____ SSN _____

Please list below those whom you would allow us to release test results and medical information to. (i.e.: spouses, children, parents, friends):

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Privacy Act and Medical Release for Insurance and Referring Physicians

I have reviewed the patient privacy act and understand that my records cannot be released without my written permission. I also authorize the release of all medical records to referring physicians and to my insurance company. **I further authorize insurance payments to be made directly to Premier Wound Care and understand that co-pays, patient balances are due at the time of service.**

Patient Signature X _____ Date _____

***SEE BACK PAGE**

Premier Wound Care, PLLC

Consent to Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination, and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
 - A means of communication among many health professionals who contribute to my care.
 - A source of information for applying my diagnosis and surgical information to my bill.
 - A means by which a third-party payer can verify that services billed were provided.
 - A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.
 - I have reviewed the office policies and payment policies of the office of Premier Wound Care. I understand that noncompliance to the policies may result in discharge from the practice of Premier Wound Care.
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I give consent to all medical care, examinations, cultures, and test including telehealth. (Audio and Video)

I give consent to allow patient data exchange with Health Information Networks (HINs) for treatment, payment and care coordination.

In accordance with HIPAA, I wish to be contacted in the following manner:

Mark all that apply: Text Email Home / Cell Phone Written Communication

Patient Photo Authorization and Release

I consent and agree to photograph(s), or medical image(s) to be taken of my wound(s) by Premier Wound Care. I understand that such photograph(s), or medical image(s) shall become the property of Premier Wound Care and any be shown, printed, or otherwise disseminated in any print, visual or electronic media. I understand that the image(s) disclosed, or some portion thereof, may be protected by the Health Information Privacy and Administration Act of 1997 (HIPAA). I further understand that Premier Wound Care is making the photograph(s), or medical image(s) in the capacity of a health care provider. I have read the above authorization and fully understand its terms.

Appointment Policy

In an effort to provide effective and efficient treatment to all our patients, it is the policy of this office that all appointment cancellations are made at least 24 hours prior to your scheduled appointment time. If an appointment is canceled three times or you are a no call, no show for three or more appointments, our clinic may choose to discharge you as a patient. If an appointment is not canceled or patient fails to show up for an appointment, Premier Wound Care reserves the right to charge the patient a \$25.00 fee per occurrence. As this fee is not billed to any insurance company, the patient accepts full responsibility to pay this fee. I have read the above policy and fully understand its terms.

Print Patient Name _____

Patient Signature X _____ Date _____

History and Physical Form

Premier Wound Care, PLLC

Patient Name _____ Date _____

Primary Care Physician _____ Referring Physician _____

Pharmacy _____ Home Health Agency _____

Have you had recent lab work done? Yes or No If so, where? _____

Have you had any diagnostic studies for this condition? X-rays? Y/N MRI? Y/N Bone Scan? Y/N CT? Y/N

Do you smoke? Yes or No Amount _____ How Long _____

Do you drink? Yes or No Amount _____ How Long _____

Do you use recreational drugs? Yes or No

Allergies: (please list all drug, food, or environmental allergies) _____

Past Medical History: (please circle all that apply)

AIDS/HIV Anemia Atrial Fibrillation Arthritis Bleeding Disorder Blood Clots Cancer Chronic Back Pain COPD / Asthma Congestive Heart Failure Coronary Artery Disease Depression	Diabetes Emphysema Gout Heart Attack Heart Problems Hepatitis Hernia High Blood Pressure High Cholesterol Irritable Bowel Syndrome Kidney Disease Liver Disease	Lung Disease Migraine Headaches Muscle, Joint, Bone Issues Myasthenia Gravis Neck Injury Neurological Disorder Neuropathy Osteoporosis Pacemaker / Defibrillator PVD Pulmonary Embolism Reflux / GERD	Rheumatoid Arthritis Seizures Sleep Apnea Stomach Ulcers Stroke Thyroid Disease Tuberculosis Other:
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Past Surgical History: (please circle all that apply)

Ankle / Foot Surgery Appendectomy Amputation Back Surgery Breast Mastectomy Carpal Tunnel Surgery Cataract Surgery C-Section Cholecystectomy	Elbow Surgery ENT Surgery Eye Surgery Gallbladder Surgery General Surgery Hand Surgery Head / Neck Surgery Heart Stent /CABG Surgery Hernia Surgery	Hip Replacement Hysterectomy Implants Knee Scope Knee Replacement Lumpectomy Pacemaker / Defibrillator Plastic Surgery Shoulder Surgery	Spine Surgery Stent Surgery Thyroid Surgery Tonsillectomy/Adenoids Vascular Surgery Wisdom Teeth Extraction Wrist Surgery Other:
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*SEE BACK PAGE

Premier Wound Care, PLLC

Phone: 731-885-8881

Fax: 731-885-5945

Authorization To Release Medical Information

I authorize Premier Wound Care to release or receive information or records via secure fax, email or by mail.

Patient Name _____ Date of Birth _____ SSN _____

Records Authorized to be Released:

- Admission History and Physical
- Discharge Summaries
- Office Notes
- Lab Reports
- Radiology Images and Reports
- Psychiatric / Mental Health Records
- Other

This authorization will expire one year from the date of the signature below. I understand that I may revoke this authorization at any time in writing to the healthcare provider, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- I am entitled to receive a copy of this authorization.

Signature of Patient or Representative X _____

Relationship to Patient _____ Date _____