ELITE
WOUND CARE
& ORTHOTICS

General Information:

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex:_____ SSN: _____

Home Address: _____

Mailing Address (If Different than Above): _____

Email Address: _____

Home Phone Number: _____ Cell Phone Number: _____

Language: _____ Race: _____ Ethnicity: _____

Marital Status (Please Circle One of the Following): Single Married Relationship Widowed

Spouse/Partner: _____ Contact Number: _____

In Case of Emergency:

Name: _____ Relationship: _____

Home Phone Number: _____ Cell Phone/Other Number: _____

Insurance Information:

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

How did you hear about us? ( ) Google ( ) Website ( ) Signage ( ) Billboard

Or who can we thank for sending you to us _____

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Medical Questionnaire:

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex:_____ SSN: _____

Are you currently a patient of any specialist or any other health provider? (E.g. Cardiologist, nephrologist, etc.)	**YES**	**NO**

If yes, please list the Providers name and specialty:

Provider:	Specialty:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Reason for Todays Visit:

_____

_____

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Are you Currently Experiencing Any of the Following Symptoms?

Anxiety/Depression	Yes___	N o	Comments: _____
Appetite Changes	Yes___	N o	Comments: _____
Blurred Vision	Yes___	N o	Comments: _____
Chest Pain	Yes___	N o	Comments: _____
Cough	Yes___	N o	Comments: _____
Diarrhea/Constipation	Yes___	No__	Comments: _____
Dizziness	Yes___	No___	Comments: _____
Fatigue	Yes___	No___	Comments: _____
Headaches	Yes___	No___	Comments: _____
Heartburn/Indigestion	Yes___	No___	Comments: _____
Insomnia	Yes___	No___	Comments: _____
Memory Loss	Yes___	No___	Comments: _____
Muscle/Joint Pain	Yes___	No___	Comments: _____
Painful Urination	Yes___	No___	Comments: _____
Recent Fall	Yes___	No___	Comments: _____
Sexual Function	Yes___	No___	Comments: _____
Shortness of Breath	Yes___	No___	Comments: _____
Swelling	Yes___	No___	Comments: _____
Weight Loss/Gain	Yes___	No___	Comments: _____

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Past Major Illnesses:

Blood Disorder	Date: _____	Kidney Disease	Date: _____
Cataracts	Date: _____	Lung Disease	Date: _____
Diabetes	Date: _____	Stroke/TIA	Date: _____
Epilepsy/Seizures	Date: _____	Swelling	Date: _____
Gallbladder Disease	Date: _____	Thyroid Problems	Date: _____
Glaucoma	Date: _____	Tuberculosis	Date: _____
Heart Disease	Date: _____		

Medical History:

Surgery:	Date:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Broken Bones:

_____

_____

_____

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Hospitalizations:

Date:	Hospital	Reason for Hospitalization:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History:

Mother: Living Deceased Age/Cause of Death: _____

Medical History: _____

Father: Living Deceased Age/Cause of Death: _____

Medical History: _____

Number of Siblings: _____ Number of Children: _____

Do you have any family in the local area? Yes No

Social History:

Do you have assistance at home:	Yes	No
Do you live by yourself?	Yes	No
Are you retired?	Yes	No
Do you have a Medical Power of Attorney or Living Will?	Yes	No

Who would assist you in an emergency? _____ Relationship: _____

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Recent Preventative Care:

Date of your last Bone Density Exam: _____

Date of your last Colonoscopy: _____

Date of your last Dental Exam/ Cleaning: _____

Date of your last Eye Exam: _____

Date of your last Hearing Exam: _____

Date of your last Mammogram: _____

Date of your last Pelvic or Pap Smear: _____

Date of your last Pneumococcal Immunization: _____

Date of your last Prostate Exam: _____

Have you received the Flu Shot this season? Yes No Date: _____

Have you received a Tetanus Immunization? Yes No Date: _____

Do you Exercise Regularly? Yes No

Do you smoke or have you ever smoked? Yes No

If so, how many years? _____ How many packs per day? _____

Do you still smoke? _____ When did you quit? _____

Do you drink alcohol? Yes No

Never *Monthly or Less* *2-4 times per month* *2-3 times per week* *4+ times per week*

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Activities of Daily Living:

Can you handle your personal care on your own? (Toileting, Eating, Walking, etc.)? Yes No

Some, please list _____

Do you do your own Cleaning?	Yes	No
Do you do your own Cooking?	Yes	No
Do you do your own Driving?	Yes	No
Do you handle your own Finances?	Yes	No
Have you ever gotten Lost?	Yes	No
Do you handle your own Medications?	Yes	No
Do you do your own Shopping?	Yes	No

If you answered no to any of these questions who does these things for you?

_____

Have you had any car accidents or near accidents in the last two years? Yes No

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Patient Authorization for the Release of Medical Records

Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

I hereby authorize **Elite Wound Care & Orthotics,** to request the medical records from

_____

Records requested are as follows:

___Lab Reports, X-Rays, EKG Reports

___History and Physical, Echocardiograms

___Nuclear/Regular Stress Tests

___ Holter Monitors

___Cath/ PTCA/ Stent Reports

___All Records

___Other: _____

_____

I specifically release of information relating to:

___Substance abuse (including alcohol/drug abuse)

___STD related information (HIV and AIDS related testing)

___Mental health (including psychotherapy notes)

_____
Signature of patient and Legal Guardian

I understand that I have the right to revoke this authorization at anytime. I also understand that I must do so in writing and present my written revocation to Elite Wound Care & Orthotics at the above address. I understand that the revocation will not apply to my insurance company when insurers contest a claim under my policy.

_____ _____ _____
Signature of patient and Legal Guardian **Date** **Relationship to Patient**

_____ _____
Witness Printed Name and Signature Date

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Release of Medical Information

I, _____ hereby give authority to_____,
Patient's Name Name and Relationship

to have access to the indicated medical information below, effective _____.
Date

___Procedures

___Medications

___Appointment times and cancellations

___Patient history

___All medical information may be released

I understand that I may request to cancel this release of information in writing for whatever reason, at anytime and that information about me or anything pertaining to me will not be released to anyone but the person mention above. I also understand that Elite Wound Care & Orthotics cannot be held liable for any misuse of information obtained by the person mentioned above.

_____ _____ _____
Signature of patient and Legal Guardian **Date** **Relationship to Patient**

_____ _____
Witness Printed Name and Signature Date

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HIPAA Compliance Patient Consent Form

Our notice of privacy practices (on the back) provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

Your rights:

- Get a copy of your health and claims records
- Ask us to correct health and claims records
- Request confidential communications
- Ask us to limit what we use or share
- Get a list of those with whom we've shared information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you feel your rights are violated

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

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Patient Financial Responsibility

As a courtesy to our patients, we have enrolled in numerous managed care insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly. However, it is not possible for us to keep track of all the individual requirements of each plan.

It is the responsibility of each patient to know the details of his or her insurance plan in addition to any lapses in insurance coverage. Any charges that occur as a result of insurance plan restrictions or lapses in coverage are ultimately the patient's responsibility. Unfortunately, if you do not inform us of special requirements required by your plan and we order medically necessary services, such as lab work, hospitalization, or supplies that are not covered by your plan; we may bill you directly for those charges. If current insurance coverage cannot be verified prior to each appointment, payment will be due at the time of service.

The office bills only for services performed by our providers. Laboratories are separate entities and will bill you or your insurance company for services that are performed. If you have any questions about your laboratory bill please contact them or your insurance company directly

Providing the highest quality of medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance plan guidelines, whenever possible. With your cooperation you should be able to receive all of the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care. Elite Wound Care & Orthotics offers a 50% discount for uninsured patients and this is payment is required at the time service is rendered.

We may charge an upfront $35.00 administrative fee for completing forms such as disability or insurance and medical records requests. Please be aware that these services may require up to seven to ten days to complete.

If an account is not paid in full within 90 days, a 25% collection-processing fee will be added to the outstanding balance and will be turned over to a collection company for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

Checks returned for any reason will be assessed a $35.00 service fee in addition to the amount of the check. NSF checks must be redeemed with certified funds and checks will no longer be permitted as payment.

We attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. Elite Wound Care & Orthotics also reserves the right to charge a no-show fee for patients who miss appointments without calling to cancel within 24 hours of the appointment. The current no-show fee is $25.00 and is subject to change without notice.

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by myself.

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By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operation
- The practice reserves the right to change the privacy policy as allowed by law
- The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease
- The practice may condition receipt of treatment upon execution of this consent

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE RECEIVED A COPY, READ, AND UNDERSTAND THE FOLLOWING POLICIES. I ACCEPT THE RIGHTS AND RESPONSIBILITIES OUTLINED WITHIN THEM:

- Patient Rights Regarding Medical Records
- HIPPA Policy and Responsibilities
- Patient Financial Responsibility including collections, no-show policy

This consent was signed by: _____

Please PRINT Name

Signature: _____ Date: _____

Witness: _____ Date: _____

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