US Wound Care & Hyperbaric Centers
Panama City Beach, Florida

Patient Name _____

New Patient Forms

Patient Name			
Patient DOB			
Patient Address			
Patient Phone Number(s) list all that apply			
Patient Email			
Emergency Contact Name		**Phone Number**	
Insurance Company		**Policy Holder Name**	
Policy Holder SSN		**Patient SSN**	

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

Medication	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: _____ _____

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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
Panama City Beach, Florida

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.

Preferred Pharmacy	Street Address	Phone Number

Primary Care Physician	Street Address	Phone Number

Other Physicians / Specialists	Specialty	Phone Number

Preferred Home Health Agency	Street Address	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
Panama City Beach, Florida

Patient Name _____

RIGHTS & RESPONSIBILITIES

Welcome to US Wound Care & 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 1-850-250-0112, 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 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. If it is medically necessary to extend your treatment beyond your initial plan of care, we will communicate with the physician to update the prescription. 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.

US Wound Care
& Hyperbaric Centers
Panama City Beach, Florida

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
Panama City Beach, Florida

Patient Name _____

TREATMENT & CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether to undergo the procedure after knowing the risks and hazards involved. 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.

_____ **(Initial)** I (we) voluntarily request **Dr. Fichter** 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.

_____ **(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.

_____ **(Initial)** 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.

_____ **(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, 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 (7) Additional Surgery.

_____ **(Initial)** I (we) have been given the opportunity to ask questions about my current condition(s), the proposed procedure(s), the benefits, the likelihood of success, the 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.

_____ _____
Patient Signature **Date**

_____ _____
Patient Name (Print) **DOB**

_____ _____
Witness Signature **Date**

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**

Physician Printed Name: _____

US Wound Care & Hyperbaric Centers
Panama City Beach, Florida

Patient Name _____

PHYSICIAN CONSENT

_____ **(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(s) 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 my refuse to treat me, 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 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 to 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 maintain 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)** Email: 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. I consent to Northwest Florida Wound Care & Hyperbaric Center LLC sending unsecured emails regarding my visit to the email address I have provided on this form.

_____ **(Initial)** Consent to Wireless Telephone Calls: I consent to receive telephone calls, SMS Next, 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 HIPPA Privacy Policy and understand that if I have any questions or complaints, I should contact the Northwest Florida Wound Care & Hyperbaric Center LLC Privacy Officer at 1-855-WOUND01.

_____ _____

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

US Wound Care & Hyperbaric Centers
Panama City Beach, Florida

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, if 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.

_____ _____

Signature of Patient/Other Legally Authorized Representative **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: _____

Email Email address: _____

US Wound Care & Hyperbaric Centers
Panama City Beach, Florida

Patient Name _____

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 and Hyperbaric Center (a part of US Wound Care and Hyperbaric Centers)
Address: 11501 Hutchison Blvd. Suite 109 | Panama City Beach, FL 32407
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:

_____

_____