UNITED WOUND HEALING™

UNITED WOUND HEALING™

Dear New Patient,

We would like to take this opportunity to welcome you to our practice and to thank you for allowing our providers to take part in your healthcare. We look forward to providing you with personalized, comprehensive wound care.

At United Wound Healing, continuity and coordination of patient care is essential in meeting your wound care needs. Our providers and staff will work closely together with you and/or your legal guardian, your Home Health agency, and primary care providers to help support your wound care journey.

You will need to complete your new patient registration attached to this letter and the health history prior to your appointment.

During your initial visit, we will be reviewing your health status, and the attached forms which contain information necessary to complete this process.

Once again, we would like to thank you for allowing us to be a part of your wound care team.

We look forward to partnering with you in your wound care journey.

Sincerely,

United Wound Healing

United Wound Healing 2913 5th Ave NE #101, Puyallup, WA 98372

Our office hours are Monday-Friday 8am-4:30pm

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Patient Information (please fill in completely)

Patients Name *

First Name Last Name

Patient's Date of Birth *

Gender *

- ○ Male
- ○ Female

Race

- ☐ Asian
- ☐ Black/African America
- ☐ White
- ☐ Native American
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ Other

Patients Address *

Apt

City *

State *

Zip *

Email Address

example@example.com

Patient Primary Phone *

Patient Secondary Phone

Ok to leave a detailed message? *

- ○ Yes
- ○ No

Marital Status *

- ○ Single
- ○ Married
- ○ Divorced
- ○ Widow/Widower
- ○ Other

Emergency Contact *

Phone *

Emergency Contacts Relationship to Patient *

Responsible Party for Payment *

Printed name if other than patient

Relationship to patient

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Medical Insurance

Do you have Medical Insurance? *

- ○ Yes
- ○ No

Primary Insurance Name *

Employer *

Subscriber Name *

Subscriber Date of Birth *

Subscriber Number/ID *

Group Number *

Secondary Insurance Name

Employer

Subscriber Name

Subscriber Date of Birth

Subscriber Number/ID

Group Number

Assignment of Benefits

All Fields Must be Completed

Insurance and Payment Responsibilities

I request that payment of authorized Medicare and/or private insurance benefits be made either to me or on my behalf to InfuSystem for any services furnished to me by InfuSystem. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and/or my private insurance, and its agents, any information needed to determine these benefits for related services.

I permit InfuSystem to release the information necessary to bill and collect payments directly from my health insurance plan for all services furnished by InfuSystem.

I understand that I am responsible for charges not covered by my health insurance plan, such as co-insurance and deductible amounts.

Patient Name

Patient Date of Birth

Date

Month Day Year

Facility Name

InfuSystem Facility Account Number

IF PATIENT IS UNABLE TO SIGN, DESIGNEE SHOULD COMPLETE THE FOLLOWING INFORMATION

Designee Name

Relationship to Patient

Date

Month Day Year

Designee Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Reason Patient Cannot Sign (pick One):

- ○ Physically Unable
- ○ Mentally Unable
- ○ Other

Patient Health History

In order for us to obtain a complete medical history, it is important for you to fill out this form to the best of your knowledge. Please fill out every item. It is important for the doctor to know you have carefully reviewed every area of this form, and provided complete and accurate information so that we may provide the best care possible.

Preferred Pharmacy name and location *

Please check this box if you are NOT currently taking ANY medications

- ○ NO medications

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING.

DO YOU HAVE ANY ALLERGIES? *

- ○ YES
- ○ NO

Has the patient been diagnosed with any of the following? Check all that apply. *

- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Dementia
- ☐ Bipolar Disorder
- ☐ Parkinson's Disease
- ☐ Down Syndrome

- [ ] Stroke
- [ ] Heart Attack
- [ ] Thyroid Disease
- [ ] Congestive Heart Failure
- [ ] COPD
- [ ] Atrial Fibrillation
- [ ] Emphysema
- [ ] Asthma
- [ ] Cancer
- [ ] Diabetes
- [ ] Liver Disease
- [ ] Cerebral Palsy
- [ ] None of the Above
- [ ] Other

Does the patient use any of the following? Check all that apply. *

- [ ] Wheelchair - manual
- [ ] Wheelchair - motorized
- [ ] Walker
- [ ] Cane
- [ ] Hospital bed
- [ ] Oxygen
- [ ] Nebulizer
- [ ] Incontinence supplies
- [ ] Catheter supplies
- [ ] Ostomy supplies
- [ ] Dentures
- [ ] Hearing aids
- [ ] None of the above
- [ ] Other

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Surgeries and Hospitalizations

Please list any surgeries you have had including dates *

Have you ever been hospitalized for non-surgical reasons? *

- ○ Yes
- ○ No

If yes, please list the reason for hospitalization

Printed name if other than patient *

Relationship to Patient *

Date *

Month Day Year

Acknowledgment Notice of Privacy Practices

About our Privacy Practices We keep a record of the health care services we provide you. You may ask to see and/or obtain a copy of that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so. Or unless the law authorizes tor compels us to do so. You may see your records or get information about them by contacting our office.
Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. Please review the posted Notice of Privacy Practices in our office before your appointment.
By my signature below I acknowledge the following:
I give permission to have my information sent electronically and to be contacted via email.
I give permission to be contacted via phone/text/email with the information provided on my intake forms.

Please select an option below.

- ○ Please do not disclose my information with anyone unless the law authorizes or compels you to do so.
- ○ The person(s) (e.g. friends and/or family, caregivers) marked below may have access to my information

Printed Name

Relationship

Printed Name

Relationship

Printed Name

Relationship

Printed name if other than patient *

Relationship to Patient *

Date

Month Day Year

Additional Medical Provider Information

In order for United Wound Healing to ensure we share the correct information in regards to your wound treatment, we ask for additional information in regards to healthcare providers you are currently seeing. These providers can benefit from the information about your wound treatment, as we all work together to best serve you. Please complete the information below to the best of your ability.

Is the patient currently being seen by a Home Health Agency? *

- ○ Yes
- ○ No

If yes, please fill out the following information:

Home Health Agency

Phone Number for Agency

Who is the patient's current Primary Care Physician?

Name of Primary Care Physician *

Address of Primary Care Physician

Phone Number

Is the patient currently being seen by any other providers or specialists? If so, please provide this information below:

Name of Providers and the Type of Care Provided

Consent for the General Minor Procedures Necessary to the Practice of Wound Care and Dermatology

Authorization for medical treatment. Administration of local anesthesia and the performance of operations and/or procedures.

1) I do hereby authorize the use of and the administration of such drugs, anesthetics, and other treatments, including the performance of a wound debridement, incision and drainage, skin biopsy, the use of cryosurgery with liquid nitrogen, and the injection of intralesional Kenalog(cortisone), should any of these be deemed advisable, desirable, or necessary for diagnostics, therapeutic, or investigational purposes by any physician, physician assistant, or nurse practitioner on the medical staff of United Wound Healing, or upon me or my minor/responsible party.
2) I further consent to the examination for diagnostic, investigational purposes, and disposal by authorities of the above-named medical facility or its designates herein, of any issues or parts which may be removed. This may include the use of photography to document skin conditions.
3) I further consent to the use of non-identifiable medical information and data for the purposes of research, investigation, and publication.
4) I understand that wound debridement involves the removal of non-living tissue from a wound, and may also include the removal of living tissue, and that such removal may result in pain, bleeding, or infection at the site of wound debridement.
5) I understand that the skin biopsy involves removal of a piece of skin and that such removal may result in a permanent scar or discoloration of the skin at the site of the biopsy.
6) All biopsy specimens that are removed are sent for dermatopathological analysis. Charges for dermatopathology will be billed to my insurance carrier. I recognize that in certain cases, I may be responsible for a portion or all the charges.
7) I understand that any of these procedures may have some unwanted effects, which include, but are not limited to permanent scarring, permanent discoloration of the skin at the site of treatment, atrophy (thinning of skin), infections, bleeding, nerve damage resulting in temporary or permanent numbness or temporary or permanent loss of function of certain muscles (paralysis).
8) I recognize the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT AND THE EXPLANATIONS CONCERNING THE ABOVE ITEMS WERE MADE TO ME.

Printed name if other than patient *

Relationship to patient *

Date

Month Day Year

Chronic Care Management or Principle Care Management Consent Agreement

Medicare offers a benefit for Medicare beneficiaries to aid with the management of multiple chronic conditions. With your signature below you and/or the patient consent to this Chronic Care Management (CCM) or Principle Care Management (PCM) Consent Agreement, and to the provision of CCM or PCM services to you by United Wound Healing to the extent recommended by your provider.
CCM or PCM Services are only available to patients with two or more chronic conditions. Medicare defines a chronic condition as a condition that is expected to last for at least 12 months, and that increases the risk of death, acute exacerbation of disease, or a decline in function.
The benefits of CCM or PCM Services include:
A comprehensive plan of care for health needs, available on paper or electronically.
Should you wish to receive CCM or PCM Services through United Wound Healing, we will only bill Medicare for CCM or PCM Services once per 30-day billing cycle. Furthermore, your provider agrees only to bill Medicare for CCM or PCM Services if you have more than one chronic condition.
By signing this agreement, you agree to the following terms:
You consent to United Wound Healing providing CCM or PCM Services to you. You acknowledge that only one practitioner can give and be paid for CCM or PCM Services during a calendar month. You authorize electronic communication of your medical information between treating providers as part of your care.
You understand that CCM or PCM Services are subject to Medicare cost-sharing requirements, and so you may be billed for a portion for the CCM or PCM Services. You have the right to stop CCM or PCM Services at any time by revoking this Agreement effective at the end of the then current thirty (30) - day period of services. Upon receipt of your cancellation, United Wound Healing will give you written confirmation (including the effective date) of cancellation.

Printed name if other than patient *

Relationship to patient *

Date

Month Day Year

Patient Financial Agreement

Thank you for choosing United Wound Healing as your wound care provider! This Patient Financial Agreement, which is entered into between you and United Wound Healing, provides information about your financial responsibility for the professional services rendered by United Wound Healing's licensed health care providers.

Medical Insurance Billing: As a courtesy to you, United Wound Healing will bill your medical insurance company for the professional services that United Wound Healing providers render to you. You must provide United Wound Healing with accurate and current information about your medical insurance company. You must also notify United Wound Healing immediately if there is a change to your medical insurance coverage. By your signature below, you request that payment of authorized medical insurance benefits be made on your behalf to United Wound Healing for the services given to you by united Wound Healing and its providers.

Medicare: United Wound Healing is a participating Medicare provider. Therefore, if you are a Medicare beneficiary, you must provide your Medicare enrollment information to United Wound Healing before or at the time of your first visit. By your signature below, you request that payment of authorized Medicare benefits be made on your behalf to United Wound Healing for services given to you by United Wound Healing and its providers. You authorize any holder of medical information about you to be released to the Centers of Medicare and Medicaid Services for any information needed to determine these benefits. United Wound Healing accepts the charge determination of the Medicare carrier as the full charge and you are responsible only for any deductibles, co-insurance, co-payments, and amounts for non-covered services.

Medigap: If you are a beneficiary of a Medicare Part B supplemental plan (i.e., Medigap), you must provide your enrollment information to United Wound Healing before or at the time of your first visit. Your signature below authorizes United Wound Healing to release any information needed to determine these benefits, and you request that payment of authorized Medicare supplemental benefits be made to United Wound Healing, if possible, or otherwise to you.

Your Responsibility: You are responsible for paying all deductibles, co-insurance, co-payments, and any fees for services not covered by your medical insurance at the time services are rendered according to United Wound Healing's standard rates and terms.

You will begin receiving monthly statements with any balanced after your medical insurance has been billed. If you are not covered by an insurance company, or your insurance does not cover United Wound Healing's services, your account will be considered a self-pay account. As a self-pay account, you will be responsible for the full balance of services rendered to you, and you are to pay the full charge at the time that the services are rendered In accordance with applicable law, we reserve the right to assign your account to a collections agency if your account payments are found overdue.

Payment Methods: United Wound Healing accepts check and credit cards (Visa, MasterCard, Discover, and American Express Accounts can be set up on payment plans, if necessary, at no additional cost.

Printed name if other than patient

Relationship to patient

Date *

Month Day Year