Dear Patient,

Thank you for choosing Ultimate Wound Solutions to participate in your care.

As a participant in your own healthcare it is your responsibility to assure that there is a clear and open line of communications from our office to you. It is also your responsibility to ensure that this office always has a way to contact you.

We will at times order diagnostic testing that we feel is important to help take the best care possible of your condition. We will make all attempts to contact you with these results, if you do not hear from us within 5 days of performing these tests it is your responsibility to contact us, as it is if you call us with any issue and we do not return your call within 24 hours. We ask that you contact the office as soon as possible after any changes in address or phone numbers.

By signing this letter, you are agreeing that the responsibilities and obligations listed above are important and that you will comply with these obligations.

Thank you and we look forward to seeing you.

Patient Name Printed_________________________________
Patient Signature____________________________________Date_______

PLEASE SEND BACK ASAP ATTACHED PAPER WORK

Patient Name____________________________
Appointment Date_________________________

If you are unable to keep the appointment, please notify the office at least 24 hours in advance**. Failure to cancel the appointment without 24 hr. notice will result in a $25.00 cancellation fee.**

Copayments are due on the day of each office visit and will be collected.
If you are a cash only customer your payment will be due on the day of this visit and will be collected.

Please come prepared to present your insurance cards, photo ID and current list of medications, vitamins, supplements, over the counter meds, etc. Your cooperation in this matter is greatly appreciated.

We thank you in advance for your cooperation.
We welcome you as a patient and appreciate the opportunity to provide you with the very best care.

The physicians and staff of Ultimate Wound Solutions.

Ultimate Wound Solutions- Financial Policy

Our practice is dedicated to providing the best possible care for you and we want you to completely understand our Financial Policy.

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept most major credit cards. There will be a charge of $25.00 for returned checks.

2. Please be advised that your insurance policy is basically a contract between you and your insurance carrier. As a service to you we will file your insurance claim if you assign the benefits to the practice. In other words, you agree to have your insurance carrier pay the practice directly. If your insurance company does not pay the practice within 90 days, you will be responsible for payment in full. If the office receives payment later from your insurance company we will refund any overpayment to you.

3. Not all insurance plans cover all services. In the even that your insurance carrier determines a service to not be covered, you will be responsible for the entire charge. Payment is due upon receipt of a statement from our office.

4. We are participating providers with several insurance companies. Prior arrangements have been made to accept assignment of benefits. We will bill the insurance carrier for services provided. However, you are required to make your co-payment or a deductible at the time of service.

5. If we do not participate with your insurance company, you will be responsible for paying your charges at the time of service.

6. If you provide false or incorrect information you will be responsible for any unpaid claims for all services provided.

7. If the undersigned fails to pay for services rendered and collection efforts become necessary, the undersigned agrees to be responsible for all collection costs incurred, including but not limited to contingency or collection fees added by a third party to the original balance.

I have read and understand the Financial Policy of Ultimate Wound Solutions and I agree to be bound by its terms. I also understand and agree that such terms may be amended by Ultimate Wound Solutions from time to time.

Signature of Patient____Date___________________
Print Name of Patient____ Date___________________
Signature of responsible party if patient unable to sign___________________________________
Date___________

PATIENT HISTORY
DATE______________

GENERAL INFORMATION

NAME____HOME PHONE______________________
ADDRESS____CELL PHONE___________________
CITY____________________________STATE___________________ZIP CODE________________
EMAIL____
DATE OF BIRTH ____________AGE ____SEX ____Do you live alone? YES___ NO____________
Do you drive? YES___ NO___ Marital Status: Single __Married__ Divorced __
Separated ____Widowed__
Height_____Weight_______**ALLERGIES**____
____
____

EMERGENCY CONTACT INFORMATION

NAME____________________________________HOME PHONE_________________________
RELATIONSHIP_____________________________ CELL PHONE__________________________

PRIMARY PHYSICIAN

NAME____________________________________PHONE__________________________________
ADDRESS__________________________________CITY___________STATE_____ZIPCODE_______
HOME HEALTH AGENCY/NURSING HOME/ASSISTED LIVING___________________________
PHARMACY_________________________________PHONE__________________________________
DO YOU HAVE ANY OF THE FOLLOWING?

ADVANCE DIRECTIVE_____LIVING WILL____MEDICAL POWER OF ATTORNEY__________
DO NOT RESUSCITATE_____ COPY PROVIDED____

INSURANCE INFORMATION

Insurance Company ________________________Policy Number____________________________
Payment Type ____________________________Group number_____________________________
Full Name of Insured______________________ Effective Date_____________________________
Insured Date of Birth______________________ Terminated Date__________________________
Relationship to Insured ____________________Insured Employer_________________________
SS# of Insured ____________________________Insured ID_________________________________
Insurance Phone number___________________

WOUND HISTORY

WOUND LOCATION____
When did the wound first appear ____?
Has it ever healed and then reopened? YES__NO__
How did it first start? Blister __bite___ bruise ___burn ___chemical burn ___Radiation burn__________ gradual appearance__ unknown __pimple __pressure __surgical __trauma __ caused by footwear_____other____
Who has been treating the wound until now?____
____

Have you had any lab work done in the last 30 days? YES __NO __if so who ordered it______________
____
Have you tested positive for antibiotic resistant organisms/(MRSA, VRE)
YES__ NO__ Date____
Have you tested positive for osteomyelitis (BONE INFECTION)? YES__NO___
date____
Have you had any tests for circulation on your legs? YES__NO__DATE_________________________
If so where____
Have you had any other problems with your wound? INFECTION___________________________
SWELLING____ ODOR______ REDNESS ______PAIN ___If so Pain level on scale of 1 to 10_____
OTHER______________________________

REFERRAL INFORMATION: Please check of how you heard about us

Internet __Magazine __Newspaper __Other Patient __Our Website__ Television __Yellow Pages

Physician Referral__ If so name of physician____
Hospital or Urgent Care Referral __If so Name____

PERSON COMPLETING FORM_____________________________RELATIONSHIP_____________
DATE____

REVIEWED BY _____________________________DATE__________________________________
PHYSICIAN/ARNP/PA SIGNATURE___________________________DATE__________________

UWS | ULTIMATE WOUND SOLUTIONS
Conventional and Alternative Wound Care

PATIENT MEDICAL HISTORY (Please mark yes or no for each question)

CARDIOVASCULAR	YES	NO
Angina		
Congestive Heart Failure		
Coronary Artery Disease		
Deep Vein Thrombosis		
Hypertension		
Myocardial Infarction		
Peripheral Artery Disease		
Peripheral Venous Disease		
Stroke		
Vasculitis		
Pacemaker		
Defibrillator		

MUSCULOSKELETAL	YES	NO
Gout		
Osteoarthritis		
Rheumatoid Arthritis		
Carpal Tunnel		
Fibromyalgia		
Muscular Dystrophy		

EAR,MOUTH NOSE THROAT	YES	NO
Chronic Sinus Problems		
Middle Ear Problems		
Trouble swallowing		
Hearing Problem(s)		

ENDOCRINE	YES	NO
Hyperthyroidism		
Hypothyroidism		
Hypoglycemia		
Diabetes		
Insulin/ Insulin Pump		
Last HgbA1C results________		

HEMATOLOGIC/LYMPHATIC	YES	NO
Leukocytopenia		
Anemia		
Lymphedema		
Sickle Cell Disease		
Thrombocytopenia		
HIV		
Bleeding Disorders		
Lymphoma		

INTEGUMENTARY	YES	NO
History of Burn		
History of Radiation		

HISTORY OF CANCER	YES	NO
If Yes, Type of Cancer:		
History of Chemotherapy		

GASTROINTESTINAL	YES	NO
Cirrhosis		
Colitis		
Chron's Disease		
Hepatitis		
Heartburn		
Diarrhea		

NEUROLOGICAL	YES	NO
Dementia		
Epilepsy		
Seizure history		
Neuropathy		
Paraplegia		
Quadriplegia		
Migraines		
Balance Disorder(s)		

PULMONARY	YES	NO
Asthma		
Emphysema		
Pulmonary Embolism		
COPD		
Collapsed Lung		
Oxygen Use		
Sleep Apnea		
CPAP Use		

EYES	YES	NO
Cataracts		
Diabetic Retinopathy		
Glaucoma		

GENTIOURINARY	YES	NO
Dialysis		
End Stage Kidney Disease		
Enlarged Prostrate		
Interstim Device		

IMMUNE SYSTEM	YES	NO
Lupus		
Raynaud's Syndrome		
Scleroderma		
Sjogren's Disease		

BEHAVIORAL HEALTH	YES	NO
Depression		
Anxiety		
Bulimia		
Schizophrenia		
Alcoholism		

CONDITION	Paternal Grandmother	Paternal Grandfather	Maternal Grandmother	Maternal Grandfather	Mother	Father	Siblings
Diabetes							
CANCER							
HEART DISEASE /HYPERTENSION							
KIDNEY DISEASE							
LUNG DISEASE							
SEIZURES							
Stroke							
THYROID							

HOSPITALIZATIONS OR SURGERIES:

HOSPITAL NAME	REASON FOR HOSPITALIZATION	DATE

PLEASE PROVIDE A CURRENT MEDICATION LIST****
INCLUDING OVER THE COUNTER, VITAMINS AND HERBAL SUPPLEMENTS

MEDICATION	DOSE	FREQUENCY

ALLERGIES:

____

____

____

____

ALCOHOL USE:

Never:__________ Occasional:__________ Frequent:__________

Number of Drinks per week:_____________

TOBACCO USE:

Never:__________ Occasional:__________ Frequent:__________

SUBSTANCE ABUSE:

Prescription drug

Never:__________ Occasional:__________ Frequent:__________

Illegal drugs

Never:__________ Occasional:__________ Frequent:__________

IMMUNIZATIONS:

Flu Vaccine Date Last Received______________
Pneumonia vaccine Date Received __________________
Tetanus Vaccine Date Last Received ______________
Shingle Vaccine Date Received __________________

PERSON COMPLETING THE FORM____
RELATIONSHIP_______________________________DATE______________________________
REVIEWED BY:_______________________________DATE_________________________________

Nestlé NutritionInstitute

Self-MNA®

Mini Nutritional Assessment

For Adults 65 years of Age and Older

Last name: First name:

Date: Age:

Complete the screen by filling in the boxes with the appropriate numbers. Total the numbers for the final screening score.

Screening		
A Has your food intake declined over the past 3 months? [ENTER ONE NUMBER] *Please enter the most appropriate number (0, 1, or 2) in the box to the right.*	0 = severe decrease in food intake 1 = moderate decrease in food intake 2 = no decrease in food intake	☐
B How much weight have you lost in the past 3 months? [ENTER ONE NUMBER] *Please enter the most appropriate number (0, 1, 2 or 3) in the box to the right.*	0 = weight loss greater than 7 pounds 1 = do not know the amount of weight lost 2 = weight loss between 2 and 7 pounds 3 = no weight loss or weight loss less than 2 pounds	☐
C How would you describe your current mobility? [ENTER ONE NUMBER] *Please enter the most appropriate number (0, 1, or 2) in the box to the right.*	0 = unable to get out of a bed, a chair, or a wheelchair without the assistance of another person 1 = able to get out of bed or a chair, but unable to go out of my home 2 = able to leave my home	☐
D Have you been stressed or severely ill in the past 3 months? [ENTER ONE NUMBER] *Please enter the most appropriate number (0 or 2) in the box to the right.*	0 = yes 2 = no	☐
E Are you currently experiencing dementia and/or prolonged severe sadness? [ENTER ONE NUMBER] *Please enter the most appropriate number (0, 1, or 2) in the box to the right.*	0 = yes, severe dementia and/or prolonged severe sadness 1 = yes, mild dementia, but no prolonged severe sadness 2 = neither dementia nor prolonged severe sadness	☐
Please total all of the numbers you entered in the boxes for questions A-E and write the numbers here:		☐☐

Now, please CHOOSE ONE of the following two questions – F1 or F2 – to answer.

Question F1

Height (feet & inches)	Body Weight (pounds)			
4’10”	Less than 91	91 – 99	100 – 109	110 or more
4’11”	Less than 94	94 – 103	104 – 113	114 or more
5’0”	Less than 97	97 – 106	107 – 117	118 or more
5’1”	Less than 100	100 – 110	111 – 121	122 or more
5’2”	Less than 104	104 – 114	115 – 125	126 or more
5’3”	Less than 107	107 – 117	118 – 129	130 or more
5’4”	Less than 110	110 – 121	122 – 133	134 or more
5’5”	Less than 114	114 – 125	126 – 137	138 or more
5’6”	Less than 118	118 – 129	130 – 141	142 or more
5’7”	Less than 121	121 – 133	134 – 145	146 or more
5’8”	Less than 125	125 – 137	138 – 150	151 or more
5’9”	Less than 128	128 – 141	142 – 154	155 or more
5’10”	Less than 132	132 – 145	146 – 159	160 or more
5’11”	Less than 136	136 – 149	150 – 164	165 or more
6’0”	Less than 140	140 – 153	154 – 168	169 or more
6’1”	Less than 144	144 – 158	159 – 173	174 or more
6’2”	Less than 148	148 – 162	163 – 178	179 or more
6’3”	Less than 152	152 – 167	168 – 183	184 or more
6’4”	Less than 156	156 –171	172 – 188	189 or more
Group	0	1	2	3

Please refer to the chart on the left and follow these instructions:

1. Find your height on the left-hand column of the chart.
2. Go across that row and circle the range that your weight falls into.
3. Look to the bottom of the chart to find out what group number (0, 1, 2, or 3) your circled weight range falls into.

Write the Group Number (0, 1, 2, or 3) here: ☐

Write sum of questions A-E (from page 1) ☐

Lastly, calculate the sum of these 2 numbers. This is your SCREENING SCORE: ☐

Question F2 DO NOT ANSWER QUESTION F2 IF QUESTION F1 IS ALREADY COMPLETED.

Measure the circumference of your LEFT calf by following the instructions below:

1. Loop a tape measure all the way around your calf to measure its size.
2. Record the measurement in cm: ________________
   - If less than 31cm, enter “0” in the box to the right.
   - If 31cm or greater, enter “3” in the box to the right.

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☐

Write the sum of questions A-E (from page 1) here: ☐☐

Lastly, calculate the sum of these 2 numbers. This is your SCREENING SCORE: ☐☐

Screening Score (14 points maximum)

12–14 points:	Normal nutritional status
8–11 points:	At risk of malnutrition
0–7 points:	Malnourished

Copy your SCREENING SCORE: ☐☐

If you score between 0-11, please take this form to a healthcare professional for consultation.

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HIPAA PATIENT AUTHORIZATION FORM

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing this Authorization and you are advised to do so.

By signing this form, you authorize our use and disclosure to third parties, including but not limited to our billing and scheduling software provider, _______, of your PHI for treatment, payment, and health care operations, and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this Authorization but later change your mind, you have the right to revoke this Authorization by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Authorization.

The patient understands and agrees that:

UWS has a Notice of Privacy Practices. The patient has received, and had the opportunity to review, this Notice before signing this Authorization. UWS encourages all patients to review the Notice of Privacy Practices.

UWS reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients.

UWS or its business affiliates may use your PHI to contact you with appointment reminders and Educational items in the future via email, U.S. Mail, telephone, fax and/or prerecorded messages. We WILL NOT ever sell or "SPAM" your personal contact information.

The patient has the right to restrict the uses of his or her information, but UWS does not have to agree to all such restrictions

The patient's medical records and protected health information may be disclosed or used for treatment, health care operations or payment, and for certain marketing purposes. UWS will not receive any payment from a third party for marketing purposes in connection with the use or disclosure of your PHI.

The patient may revoke this Authorization in writing at any time and all future disclosures that require the patient's prior written authorization will then cease. See the Notice of Privacy Practices for additional details.

UWS may not condition your treatment or payment on whether you sign this Authorization.

Information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

The Authorization was signed by: ____

Printed Name - Patient or Representative

____

Signature Date

Relationship to Patient
(if other than patient):

Witness: ____

Printed Name - UWS Representative

____

Signature Date

ULTIMATE WOUND SOLUTIONS
Conventional and Alternative Wound Care

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practice. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below, I authorize being contacted for reminders by:

__ Phone: Cell:____________ __Home:__________________Work:________________

__ Voicemail:_______________________________________

__ Email:____

__Text Message:____________________________________

By checking the lines below, I authorize being contacted for birthday greetings or promotions

about the practice by:

__ Mail

__Email

__Voicemail

__Text Message

____ ____________________

Patient Name (please print) Date

____

Name of Parent, Guardian or Patient's legal representative

*** THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.**

List below the names and relationship of people to whom you authorize the practice to release PRIVATE HEALTH INFORMATION.

__________________________ ______________________________

__________________________ ______________________________

__________________________ ______________________________

Photo Consent

It is the policy of Ultimate Wound Solutions to document wound assessments. Photography will be used as an adjunct to the assessment documentation. Photography and video testimonies may be used for education, publication and in marketing for Ultimate Wound Solutions.

Patient Name____
Date of Birth____
Male____ Female_______
Patient Number_______________________________________

If you have any further questions, please ask as we are here to help you. You have the right to change your mind at any time, including after you have signed this form. If you change your mind after you signed a consent you will need to put it in writing to Ultimate Wound Solutions.

PATIENT AGREEMENT

I understand the risks and benefits described to me by the health professional.
I understand that I have a choice not to have the wound photography or video.
I understand the recorded information will be used to support my treatment.
__ I consent to the pictures being taken and stored safely with my health records
__ I do consent for Ultimate Wound Solutions using my wound photos and video testimony for educational and marketing purposes.
__ I *do not* consent to having a picture being done.
__ I *do not* consent to a video testimony being done

Signature _______________________________________Date ______________

Full name of Legal Guardian if a child____________________________________

Witness Signature _______________________________ Date ______________