Patient History

Date: _____

General Information

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____

Email: _____

Date of Birth: _____ Age: _____ Sex: _____ Do you live alone: ☐ No ☐ Yes Do you drive: ☐ No ☐ Yes

Emergency Contact Information

Name: _____ Home Phone: _____

Relationship: _____ Cell Phone: _____

What physician suggested you visit this Center?

Name: _____ Specialty: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Who is your primary physician?

Name: _____ Specialty: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Health Care/Nursing Home: _____ Phone: _____

Pharmacy: _____ Phone: _____

Do you have any of the following?

Advanced Directive: ☐ Yes* ☐ No **Living Will:** ☐ Yes* ☐ No **Medical Power of Attorney:** ☐ Yes* ☐ No **Do Not Resuscitate:** ☐ Yes* ☐ No

*Copy Required to be in Chart: Initials: _____ Date: _____ Time: _____

☐ Copy Provided: Initials: _____ Date: _____ Time: _____

Wound History:

Wound Location: _____

When did you first notice the wound? _____

Has it ever healed and then re-opened? ☐ Yes ☐ No

How did your wound start (wounding event)? ☐ Bite ☐ Blister ☐ Bruise ☐ Bump ☐ Chemical Burn ☐ Footwear ☐ Frostbite ☐ Gradually Appeared ☐ Not Known ☐ Other Lesion ☐ Pimple ☐ Pressure ☐ Radiation Burn ☐ Surgical ☐ Thermal Burn ☐ Trauma ☐ Other: _____

How have you been treating your wound until now? _____

_____

Have you had any lab work done in the past month? ☐ No ☐ Yes, Who Ordered: _____

Have you tested positive for an antibiotic resistant organism (MRSA, VRE)? ☐ No ☐ Yes, Date: _____

Have you tested positive for osteomyelitis (bone infection)? ☐ No ☐ Yes, Date: _____

Have you had any tests for circulation on your legs? ☐ No ☐ Yes, Where done: _____

Who Ordered: _____

Have you had any other problems associated with your wound? (Please Check) ☐ Infection ☐ Swelling

☐ Other: _____

Person Completing Form: _____ Relationship to Patient: _____ Date: _____ Time: _____
Signature

Reviewed By: _____ _____
RN Signature Date Time Physician Signature Date Time

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Healogics Form: C312F_Patient History.doc • Revised (9/2012)
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Patient's Medical History *(Please check Yes or No for each Item.)*

Cardiovascular	Yes	No
Angina		
Congestive Heart Failure		
Coronary Artery Disease		
Deep Vein Thrombosis		
Hypertension		
Hypotension		
Myocardial Infarction		
Peripheral Arterial Disease		
Peripheral Venous Disease		
Stroke		
Vasculitus		

Gastrointestinal	Yes	No
Cirrhosis		
Colitis		
Crohn's Disease		
Hepatitis (Type: _____)		

Neurological	Yes	No
Dementia		
Epilepsy		
History of Seizures		
Neuropathy		
Paraplegia		
Quadriplegia		

Pulmonary	Yes	No
Emphysema		
Pulmonary Embolism		
Asthma		
Chronic Obstructive Pulmonary Disease		
Collapsed Lung/Pneumothorax		
Use Supplemental Oxygen		

Musculoskeletal	Yes	No
Gout		
Osteoarthritis		
Rheumatoid Arthritis		

Ear / Nose / Mouth / Throat	Yes	No
Chronic Sinus problems/congestion		
Middle ear problems		

Immunizations: *When was your last tetanus shot?*

Endocrine	Yes	No
Hyperthyroid		
Hypothyroid		
Diabetes		

If Yes*, for how long:

Do you take: ☐ Insulin ☐ Oral Agents ☐ Diet Controlled

Do you test your blood sugar every day?

☐ Yes How Often:_____ ☐ No

What are your usual blood sugar results:

Breakfast: _____ Lunch: _____ Dinner: _____ Bedtime: _____

Eyes	Yes	No
Cataracts		
Diabetic Retinopathy		
Glaucoma		

Genitourinary	Yes	No
Dialysis		
End Stage Renal Disease		

Hematologic/Lymphatic	Yes	No
Anemia		
Leukocytopenia		
Lymphedema		
Sickle Cell Disease		
Thrombocytopenia		

Immunological	Yes	No
Lupus		
Raynaud's Syndrome		
Scleroderma		

Integumentary	Yes	No
History of Burn		

Oncological	Yes	No
History of Chemotherapy		
Type:		
History of Radiation		

Psychiatric	Yes	No
Confinement Anxiety		
Depression		

Reproductive	Yes	No
Miscarriage		

Any implantable devices?

Family Medical History *(Please indicate with a checkmark if any of your family members have/had this condition.)*

CONDITION	Maternal Grandparents	Paternal Grandparents	Mother	Father	Siblings
Cancer					
Diabetes					
Heart Disease					
Hereditary Spherocytosis					
Hypertension					
Kidney Disease					
Lung Disease					
Seizures					
Stroke					
Thyroid					
Tuberculosis					

Hospitalization/Surgery History *(Please list all past hospitalizations.)*

NAME OF HOSPITAL	PURPOSE OF HOSPITALIZATION	DATE

Notes: _____

Please provide a list of your current medications or bring your current medications, including over the counter medications, herbal supplements and vitamins to the Wound Care Center for your first visit.

Person Completing Form: _____ **Relationship to Patient:** _____ **Date:** _____ **Time:** _____
Signature

Reviewed By: _____ _____
RN Signature Date Time Physician Signature Date Time

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Healogics Form: C3125_Patient History.doc • Revised (9/2012)
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REVIEW OF SYSTEMS

Constitutional:
- Good General health lately ☐ Yes ☐ No ☐ Past ☐ Current
- Recent weight change ☐ Yes ☐ No ☐ Past ☐ Current
- Fever ☐ Yes ☐ No ☐ Past ☐ Current
- Fatigue ☐ Yes ☐ No ☐ Past ☐ Current
- Pain ☐ Yes ☐ No ☐ Past ☐ Current

Eyes:
- Blurred/ Double Vision ☐ Yes ☐ No ☐ Past ☐ Current
- Poor vision/ Glasses/ Contacts ☐ Yes ☐ No ☐ Past ☐ Current
- Eye Disease ☐ Yes ☐ No ☐ Past ☐ Current
- Describe:

Ears/ Nose/ Mouth/ Throat:
- Ringing in ears ☐ Yes ☐ No ☐ Past ☐ Current
- Change in hearing ☐ Yes ☐ No ☐ Past ☐ Current
- Deafness / Hearing aid ☐ Yes ☐ No ☐ Past ☐ Current
- Sore Throat ☐ Yes ☐ No ☐ Past ☐ Current
- Trouble Swallowing ☐ Yes ☐ No ☐ Past ☐ Current

Cardiovascular:
- Rheumatic Fever ☐ Yes ☐ No ☐ Past ☐ Current
- Heart Attack ☐ Yes ☐ No ☐ Past ☐ Current
- Stroke ☐ Yes ☐ No ☐ Past ☐ Current
- CHF / Chest Pain ☐ Yes ☐ No ☐ Past ☐ Current
- Palpitations ☐ Yes ☐ No ☐ Past ☐ Current
- Hypertension ☐ Yes ☐ No ☐ Past ☐ Current
- Phlebitis / Blood Clot ☐ Yes ☐ No ☐ Past ☐ Current
- Pacemaker ☐ Yes ☐ No ☐ Past ☐ Current
- Swelling Legs / Ankles ☐ Yes ☐ No ☐ Past ☐ Current

Respiratory:
- Frequent colds ☐ Yes ☐ No ☐ Past ☐ Current
- Difficulty breathing / SOB ☐ Yes ☐ No ☐ Past ☐ Current
- Asthma / hay fever ☐ Yes ☐ No ☐ Past ☐ Current
- COPD ☐ Yes ☐ No ☐ Past ☐ Current
- Tuberculosis ☐ Yes ☐ No ☐ Past ☐ Current

Gastrointestinal:
- Heartburn ☐ Yes ☐ No ☐ Past ☐ Current
- Vomiting ☐ Yes ☐ No ☐ Past ☐ Current
- Constipation ☐ Yes ☐ No ☐ Past ☐ Current
- Diarrhea ☐ Yes ☐ No ☐ Past ☐ Current
- Blood in stools ☐ Yes ☐ No ☐ Past ☐ Current
- Peptic ulcer ☐ Yes ☐ No ☐ Past ☐ Current
- Abdominal pain ☐ Yes ☐ No ☐ Past ☐ Current

Integumentary:
- Rash ☐ Yes ☐ No ☐ Past ☐ Current
- Masses / lumps ☐ Yes ☐ No ☐ Past ☐ Current
- Birthmarks / warts/ lumps/ nodules ☐ Yes ☐ No ☐ Past ☐ Current
- Bleeding / bruising tendency ☐ Yes ☐ No ☐ Past ☐ Current
- Gangrene ☐ Yes ☐ No ☐ Past ☐ Current

Musculoskeletal:
- Leg pain (rest or walking) ☐ Yes ☐ No ☐ Past ☐ Current
- Back pain ☐ Yes ☐ No ☐ Past ☐ Current
- Joint pain / swelling ☐ Yes ☐ No ☐ Past ☐ Current

Endocrine:
- Excessive Thirst ☐ Yes ☐ No ☐ Past ☐ Current
- Thyroid Disease ☐ Yes ☐ No ☐ Past ☐ Current
- Heat / Cold Intolerance ☐ Yes ☐ No ☐ Past ☐ Current
- Diabetes ☐ Yes ☐ No ☐ Past ☐ Current
  - Controlled? ☐ Yes ☐ No ☐ Past ☐ Current
  - Uncontrolled? ☐ Yes ☐ No

Psychiatric:
- Depression / anxiety ☐ Yes ☐ No ☐ Past ☐ Current
- Change in memory ☐ Yes ☐ No ☐ Past ☐ Current

Immunologic:
- Rheumatoid Arthritis ☐ Yes ☐ No ☐ Past ☐ Current
- Lupus ☐ Yes ☐ No ☐ Past ☐ Current
- Scleroderma ☐ Yes ☐ No ☐ Past ☐ Current
- Vasculitis ☐ Yes ☐ No ☐ Past ☐ Current
- HIV/AIDS ☐ Yes ☐ No ☐ Past ☐ Current

Neurological:
- Spinal Cord Injury ☐ Yes ☐ No ☐ Past ☐ Current
- Seizures ☐ Yes ☐ No ☐ Past ☐ Current
- Tremors ☐ Yes ☐ No ☐ Past ☐ Current
- Numbness / Tingling ☐ Yes ☐ No ☐ Past ☐ Current
- Difficulty with balance ☐ Yes ☐ No ☐ Past ☐ Current
- Paralysis ☐ Yes ☐ No ☐ Past ☐ Current
- Aphasia ☐ Yes ☐ No ☐ Past ☐ Current
- Changes in sensation ☐ Yes ☐ No ☐ Past ☐ Current
  - Describe:

Hematologic / Lymphatic:
- Blood borne disease ☐ Yes ☐ No ☐ Past ☐ Current
- Anemia ☐ Yes ☐ No ☐ Past ☐ Current
- Blood abnormalities ☐ Yes ☐ No ☐ Past ☐ Current
- Sickle Cell Disease ☐ Yes ☐ No ☐ Past ☐ Current

Genitourinary:
- Renal Disease / Dialysis ☐ Yes ☐ No ☐ Past ☐ Current
- Difficulty with Urination ☐ Yes ☐ No ☐ Past ☐ Current
- Frequent / burning urination ☐ Yes ☐ No ☐ Past ☐ Current
- Incontinence ☐ Yes ☐ No ☐ Past ☐ Current
- Blood in urine ☐ Yes ☐ No ☐ Past ☐ Current
- Menses/ Vaginal Bleeding/ Pain ☐ Yes ☐ No ☐ Past ☐ Current
- Testicular / Prostate Problems ☐ Yes ☐ No ☐ Past ☐ Current
- Sexually Transmitted Disease ☐ Yes ☐ No ☐ Past ☐ Current

Other:
- Cancer _____ ☐ Yes ☐ No ☐ Past ☐ Current
- Chemotherapy ☐ Yes ☐ No ☐ Past ☐ Current
- Radiation Treatment ☐ Yes ☐ No ☐ Past ☐ Current
- Evidence of Abuse / Neglect ☐ Yes ☐ No ☐ Past ☐ Current

Additional Information: _____

_____

_____

_____

_____

_____

Practitioner Signature: _____ Date/Time: _____

(Patient Label / Addressograph)

Patient Consent to Wound Care Treatment

(Note: This form is to be signed by all Wound Care Center Patients. If Patient is going to receive Hyperbaric Oxygen Therapy, then Patient must also execute the *Patient Consent to Hyperbaric Oxygen Therapy Treatment* Consent Form).

Patient Name: _____ **Date of Birth:** _____

Hospital: _____

Patient hereby voluntarily consents to wound care treatment by Physician, Hospital and its contractor HEALOGICS, INC. ("HI") and their respective employees, agents, representatives, and affiliated companies (hereinafter sometimes collectively referred to as Wound Care Center – "WCC"). Patient understands that this Consent Form will be valid and remain in effect from the date of signature, as long as Patient receives care, treatment and services at the Wound Care Center. A new consent will be obtained when a patient is discharged from the WCC and returns for care, treatment or services. Patient has the right to give or refuse consent to any proposed procedure or treatment at any time prior to its performance.

General Description of Wound Care Treatment: Wound care treatment may include, but shall not be limited to: debridements, dressing changes, biopsies, skin grafts, off loading devices, physical examinations and treatment, diagnostic procedures, laboratory work (such as blood, urine and other studies), x-rays, other imaging studies and administration of medications prescribed by a physician.

Benefits of Wound Care Treatment: The benefits of treatment include: enhanced wound healing and reduced risks of amputation and infection.

Risks/Side Effects of Wound Care Treatment: May include, but not be limited to: infection, ongoing pain and inflammation, potential scarring, possible damage to blood vessels or surrounding areas such as organs and nerves, bleeding, allergic reaction to topical and injected local anesthetics or skin prep solutions, removal of healthy tissue, prolonged healing or failure to heal.

Likelihood of achieving goals: Patients who follow the physician's plan of care are more likely to have a better outcome, however, any procedures/treatments carry the risk of unsuccessful results, complications, and injuries, from both known and unforeseen causes, and no warranty or guarantee is made for any result or cure.

Alternative to Wound Care Treatment: A patient may refuse wound care treatment altogether, although the risks and side effects of doing so should be carefully considered. In lieu of treatment in the WCC, patients may continue a course of conservative treatment with their personal physician or forego any treatment.

Benefit of Alternative to Wound Care Treatment: The patient, who chooses to continue a course of conservative treatment with their personal physician or forego any treatment, may not experience the risks/side effects associated with treatment in the WCC (see **Risks/Side Effects of Wound Care Treatment** above).

Risks/Side Effects of Alternative for Wound Care Treatment: Risks of alternative wound care treatment include prolonged healing or failure to heal, infection and possible amputation if wound is on a limb.

General Description of Wound Debridements: Wound Debridement is the removal of unhealthy tissue from a wound to promote healing. During the course of wound treatment, multiple wound debridements may be necessary and will be performed by the authorized practitioner.

Risks/Side Effects of Wound Debridement: The risks or complications of wound debridement include, but are not limited to: potential scarring, possible damage to blood vessels or surrounding areas such as organs and nerves, allergic reactions to topical and injected local anesthetics or skin prep solutions, bleeding, removal of healthy tissue, infection, ongoing pain and inflammation, and failure to heal. Patient understands that debridement may make the wound larger due to the removal of necrotic (dead) tissue from the margins of the wound.

Patient Initials: _____

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Healogics Form: C318F_Patient Consent to Wound Care Treatment.doc
Revised (09/2012)
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Patient Consent to Wound Care Treatment

Patient Identification and Wound Images: Patient understands and consents that images (digital, film, etc.), may be taken by the WCC of Patient and all Patient's wounds with their surrounding anatomic features. Patient further agrees that their referring physician or other treating physicians may receive communications, including these images, regarding Patient's treatment plan and results. The images are considered part of the medical record and will be handled in accordance with federal laws regarding the privacy, security and confidentiality of such information. Patient understands that the WCC will retain the ownership rights to these images, but that the patient will be allowed access to view them or obtain copies. Patient understands that these images will be stored in a secure manner that will protect privacy and that they will be kept for the time period required by law and/or hospital policy. Patient waives any and all rights to royalties or other compensation for these images. Images that identify the Patient will only be released and/or used outside the WCC upon written authorization from the Patient or Patient's legal representative.

Use and Disclosure of Protected Health Information (PHI): Patient consents to HI's use of PHI, results of patient's medical history and physical examination, and wound images obtained during the course of Patient's wound care treatment and stored in the HI wound database for purposes of, education, research, quality management activities, ongoing analysis, data aggregation and development of proprietary clinical processes and healing algorithms. Patient's PHI may be disclosed by HI to its affiliated companies, and third parties who have executed a Business Associate Agreement. Disclosure of Patient's PHI shall be in compliance with the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Patient specifically authorizes use and disclosure of patient's PHI by HI, its affiliates, and business associates for purposes related to treatment, payment, and health care operations. If Patient wishes to request a restriction to how his/her PHI may be used or disclosed, Patient may send a written request for restriction to HI's Chief Compliance Officer at 5220 Belfort Road, Suite 130, Jacksonville, Florida, 32256. If the PHI is owned by the Hospital or another entity, HI will direct Patient's request to the appropriate party.

Financial Responsibility: Patient understands that regardless of their assigned insurance benefits, Patient is responsible for any amount not covered by insurance. Patient authorizes medical information about Patient to be released to any payor and their respective agent to determine benefits or the benefits payable for related services.

The Patient's medical condition has been explained to the Patient. The risks, benefits and alternatives of all care, treatment and services that Patient will undergo while a patient at the WCC have been discussed. Patient understands the nature of their medical condition, the risks, alternatives and benefits of treatment, and the consequences of failure to seek or delay treatment for any conditions. Patient fully understands this consent to care, treatment, and services and agrees to its contents. The Patient has read this Consent Form or had it read to him/her. The Patient has had the opportunity to ask questions and has received answers to all of Patient's questions.

Patient Signature or parent (if minor)	Relationship	Date	Time
Witness Signature		Date	Time

In the event above not signed by patient, the undersigned acknowledges that they have the legal right to sign the document.

Legal Guardian or Legal Representative	Date	Time

Printed Name: _____

Relationship: _____

The undersigned Physician has explained to the Patient (or his or her legal representative), in layman's terms, the nature of the treatment, reasonable alternatives, benefits, risks, side effects, likelihood of achieving patient's goals, complications and consequences which are/or may be associated with the treatment or procedure(s).

Signature of Physician	Date	Time

(Patient Label / Addressograph)

Agreement to Receive Wound Care

Date: _____

This Agreement Between _____ and _____
(Patient Name) (Physician Name)

I understand that I am being seen for wound care treatment in order to assist healing of my wound(s). This treatment is known to be effective only when provided on a regular basis. Lapses in my treatment, such as missed days or sporadic days, or failure to comply with the plan of care can result in this therapy becoming less effective or ineffective. Thus, I understand that in order for my treatment to be worthwhile, it is important that I receive treatment as scheduled and follow the treatment instructions provided.

The recommended treatment program by _____ (physician name)
is that I receive treatment: _____

_____

_____

I understand that in order for me to receive treatment at _____ Wound Care Center®,

I agree to the following conditions:

1. I will appear for treament as scheduled.
2. I will follow the treatment regimen prescribed for me and I will actively seek assistance when I find myself unable to comply with the plan of care.
3. If I am unable to appear for a scheduled appointment, I will notify the Wound Care Center staff by 8:00 AM on that day. I will, also, make every arrangement possible to reschedule for that same day during regular business hours.
4. I will not miss any more than 1 (one) day of treatment in the entire recommended treatment plan.
5. I understand that a violation of any of these conditions may result in my discharge from the Wound Center's program.

I accept the above terms as a condition of my receiving treatment at:

_____
Center Name

Patient Signature: _____ Date _____ Time _____

Physician Signature: _____ Date _____ Time _____

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(Healogics Form: Agreement to Receive Wound Care_B213Fd6c • Revised (9/2013)
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Thomas Kraven, MD

Tax ID 139400037

Assignment of Benefits

To whom it may concern:

I authorize any insurance company or other responsible person(s) / entities to remit payment directly to Thomas Kraven, M.D for all medical professional fees.

I understand and agree that Thomas Kraven, M.D is a self employed physician, and his professional fees are exclusive of any / all other physicians / facility medical provider(s).

_____ _____

Print Patient / Representative Signature Patient / Representative

_____

Date

A copy of this document may serve as an original.

Insurance Verification

I certify that the following is a true and accurate reporting of any / all insurance plans current at the time that _____ received medical services as a patient of Thomas Kraven, MD, and furthermore certify that the above mentioned patient is a covered member of any/all insurance plans and has active policy benefits as of the date signed by either the patient or their authorized representative.

Plan Name	Group #	Policy #
(1)_____	_____	_____
(2)_____	_____	_____
(3)_____	_____	_____

_____ _____

Patient/Authorized Representative Date

_____

Relation of authorized representative

A copy of this document may serve as an original.

Authorization of Wound Care Staff to Access Protected Health Information

Patient Information	
Name:	
Address:	
City,State, Zip:	
Date of Birth:	
Work Phone:	Home Phone:
Cell Phone:	Email:
I want to authorize access by the Wound Care staff to any medical information that occurs concurrently with my Wound Care treatment timeframe to facilitate care. ____ Patient ____Guardian of Minor Patient ____Legally Authorized Representative of Patient	
Contact Information (if different from patient information)	
Name:	
Address:	
City, State, Zip:	
Contact Phone:	Relationship to patient:
Signature:	Date:
For Office Use Only	
Date Received:	Received by:

Authorization for Release of Protected Health Information

Patient Name: _____ **DOB:** _____
Last First M.I.
SSN: _____
MR#: _____

I authorize:
- ❑ Hunt Regional Medical Center (903-408-1634)
- ❑ Hunt Regional Community Hospital (903-886-3161)
- ❑ Hunt Regional Home Care (903-408-1950)
- ❑ Other: _____

To release to: _____
Address: _____
_____
_____
Phone Number: _____
Fax Number: _____

This information is needed for the purpose of: ❑ at the request of the individual
❑ Medical Care ❑ Insurance ❑ Litigation ❑ Other _____

Date information is needed: _____ Information to be sent via:
❑ Patient to pick up records ❑ Send by Mail ❑ Fax to _____ ❑ Electronically

TREATMENT DATES TO BE INCLUDED: _____ to _____

Please check all applicable information requested:

- ❑ Demographics Sheet
- ❑ History and Physical
- ❑ Discharge Summary
- ❑ Operative Reports
- ❑ Pathology Reports
- ❑ ER Records
- ❑ Consultation Reports
- ❑ MD Progress Notes
- ❑ Physicians Orders
- ❑ Nursing Notes
- ❑ EKG/Cardiographics
- ❑ Laboratory Reports
- ❑ Medication Records
- ❑ Diagnostic Imaging Reports
- ❑ Billing Records
- ❑ Other (please specify) _____

I understand that the information to be released may include information regarding a medical condition, which is protected by Federal Law. Unless you indicate otherwise, this information will not be released (if present) to the organization, agency or individual named on this request. I (patient name) _____ authorize the release of information regarding:

- ❑ Drug Abuse/Dependence
- ❑ Alcohol Abuse/Dependence
- ❑ HIV Test Results
- ❑ HIV/AIDS/ARC Infection
- ❑ Psychiatric Conditions

I request and authorize the above named health care provider to release the information specified to the organization, agency or individual named on this request. This authorization is subject to revocation at any time except to the extent that action has been taken and expires **180 days** from the date signed. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. The facility to whom this authorization is directed, its employees and authorized representatives are hereby released from legal responsibility or liability for the provision of informaton as authorized above. I understand that the information that is being released is subject to re-disclosure by the recipient and is no longer protected.

_____ _____
Signature of Patient **Date**

_____ _____
Signature of Authorized Party **Date**
Durable Power of Attorney
Legal Guardian
Other: _____

If the patient is unable to sign or is a minor, complete the following:
Minor of _____ age
Unable to sign because:
_____
_____
Signature of Witness **Date**

(Addressograph / Label)

Wound Care Patient Billing Information

Our Wound Care Center® (WCC) serves as a hospital outpatient clinic were doctors and nurses treat people with wounds that they may have had for a long time. **Visits to the Center will result in charges from both the hospital and doctor.**

Many times these visits will only result in a charge for a procedure such as a wound debridement, but some times they may also include a clinic visit. Sometimes, there may be charges for hyperbaric oxygen therapy, laboratory tests, x-rays, and other services that may be performed in the hospital.

We understand this can be a confusing time and have outlined various ways the payment of the services provided to you can be handled. If you have questions about the process, please feel comfortable discussing this with one of the WCC staff members.

THE HOSPITAL:

When the hospital bills your insurance company(s) for the services you received at the WCC, the bill contains charges for what is called the **technical component**. This fee includes the use of the WCC's staff, room, equipment, etc. as well as any supplies that were used. You may also see laboratory charges, radiology (x-ray) charges, and other additional services if they were provided during that billing period. Some hospitals may bill for these additional services on a separate bill.

THE DOCTOR:

Each doctor that sees and treats you will bill separately for their services. Most of the time, this bill will come from his or her office, but sometimes hospitals may bill for the doctor's charges. These charges will be for the **professional component** and includes only the services that the doctor provided.

The WCC doctors are specially trained in providing wound care and the insurance companies will know to pay for only one set of services by the codes used on the bill sent to them. They will pay a portion of the service to the hospital and a portion to the doctor. **You will not be billed twice for the same service** even though the description of the services may be the same.

OTHER DOCTORS:

There are different specialists who may be called in on your case, depending on the difficulty of your wounds, and they may submit a bill as well. These may be from the Pathologist for the professional component of the laboratory tests performed, or the Radiologist for the services rendered when x-rays were performed, etc.

These billing practices are consistent within all departments of the hospital as well as within the hospital industry. In addition, these billing procedures are frequently audited by Medicare/Medicaid and accepted as standard practice.

IF YOUR PRIMARY INSURANCE IS MEDICARE OR MEDICAID:

The hospital will bill Medicare / Medicaid and may send you a courtesy copy of your itemized bill upon request. Medicare / Medicaid will notify you when they have paid their portion of your hospital bill. If you have a secondary insurance, the hospital will also send them a bill for their portion and that company will contact you to let you know when and what they paid to the hospital. After payments are received by either your primary and/or secondary insurance, **any outstanding balances will be your responsibility**. This payment is necessary since the services were performed at a hospital outpatient department. If you are responsible for the co-payment balance, your payment may range from $15 - $82[1] per encounter depending on the services or HBO treatment rendered during your visit.

IF YOUR PRIMARY INSURANCE IS AN INDIVIDUAL / GROUP PPO OR HMO:

The hospital will bill your insurance company. You will be responsible for any deductible and/or co-payment amounts. Payment for these items may be expected at the time of service. Insurance verification will help us to identify your appropriate deductible and co-payment amounts.

IF YOU DO NOT HAVE INSURANCE COVERAGE:

Many hospitals require a payment (either in full or partial) at the time of the visit. If you are unable to pay, many hospitals will work with you to determine if you qualify for some type of assistance or will allow you to set up a payment plan. The center can refer you to the hospital's Business Office as needed. You cannot be seen in the WCC until these arrangements are completed.

IF YOU HAVE QUESTIONS REGARDING YOUR BILLS / STATEMENTS:

Please call the hospital Business Office. Hours of operation are usually between 9:00 AM and 4:30 PM (Monday thru Friday). If your question is regarding the physician's services, you will need to contact that physician's office.

Patient Signature: _____ Date: _____ Time: _____

Witness Signature: _____ Date: _____ Time: _____

[1]This cost estimate was made based on the date of this publication - 9/1/2012. This cost may vary after 2012.

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Healogics Form: A126F Patient Billing Information Form.doc • Revised (9/2011)
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