

**ORANGE COUNTY WOUND and HYPERBARIC
BAROMEDICAL PHYSICIAN ASSOCIATES MEDICAL GROUP**

Phone: (714) 973- 8777 Fax: (714) 973-8777

720 N TUSTIN Ave, Ste 100 Santa Ana, CA 92705

<p>SKIN</p> <p>Wound/Lesions YES NO</p> <p>Rash/Sores/Itching YES NO</p> <p>Bruise YES NO</p> <p>Brown staining on legs YES NO</p> <p>Dryness YES NO</p>	<p>GASTROINTESTINAL</p> <p>Bowel Incontinence YES NO</p> <p>Abdominal Pain YES NO</p> <p>Constipation YES NO</p>
<p>GEN. HEALTH</p> <p>Fever YES NO</p> <p>Chills YES NO</p> <p>Weakness YES NO</p> <p>Pain/Location YES NO</p> <p>Marked Wt. Change YES NO</p>	<p>GENITOURINARY</p> <p>Urine/Incontinence YES NO</p> <p>Painful Urination YES NO</p>
<p>ALLERGIC/IMMUNOLOGIC</p> <p>Hives/Eczema YES NO</p>	<p>HEMATOLOGY/LYMPHATIC</p> <p>Easy Bruising YES NO</p> <p>Bleeding/Clotting Disorders YES NO</p> <p>Enlarged/Swollen Glands YES NO</p>
<p>CARDIOVASCULAR</p> <p>Leg Swelling YES NO</p> <p>Chest Pain YES NO</p> <p>Palpitations/Heart Racing YES NO</p> <p>Murmur YES NO</p> <p>Dizziness YES NO</p> <p>Breathless while lying flat YES NO</p> <p>Pain after activity YES NO</p>	<p>MUSCULOSKELETAL</p> <p>Assistive Devices YES NO</p> <p>Joint pain/swelling YES NO</p> <p>Muscle pain YES NO</p> <p>Difficulty walking YES NO</p>
<p>EYES</p> <p>Glasses/Contacts YES NO</p> <p>Blurred Vision YES NO</p> <p>Cataracts YES NO</p> <p>Dry Eyes YES NO</p>	<p>NEUROLOGICAL</p> <p>Headaches YES NO</p> <p>Seizures YES NO</p> <p>Numbness/Tingling YES NO</p> <p>Sensation loss/ Neuropathy YES NO</p> <p>Pain from Neuropathy YES NO</p>

EAR/NOSE/MOUTH/THROAT			PSYCHIATRIC		
Ear Pain	YES	NO	Anxiety	YES	NO
Hearing Aid	YES	NO	Depression	YES	NO
Stuffy Nose	YES	NO	Insomnia	YES	NO
Sore Throat	YES	NO			
ENDOCRINE			RESPIRATORY		
Heat/Cold Intolerance	YES	NO	Cough	YES	NO
Excessive Thirst	YES	NO	Shortness Of Breath	YES	NO
Excessive Urination	YES	NO	Wheezing	YES	NO
SOCIAL					
Tobacco Use?	YES	NO	If yes, quantity: _____		
	For how long: _____		Type: _____		
Alcohol drinker?	YES	NO	If yes, how much/ often: _____		



WELCOME TO ORANGE COUNTY WOUND CARE!

Dear Patient,

We are pleased that you have chosen to place your trust in us for your specialty wound care.

You will be assigned a primary wound care provider at the time of your initial visit with us. You will continue to see this provider **every week** until your wound has healed, and you are discharged from our care.

Your primary wound care provider's name is: _____

Many of our patients require an additional one or two visits per week for a wound check and/or dressing change. Please be aware that you will likely have a different provider check your wound on your *dressing change visits* – and this will only be a *very quick check* for acute changes or infections. You will always return to see your primary wound care provider on a weekly basis, as he/she will be directing and coordinating your care.

When scheduling follow-up visits, please remember to always schedule with:

_____ to discuss any wound related issues or concerns.

You are in good hands. Best wishes for speedy healing!

Sincerely,

The Doctors and Staff of Orange County Wound & Hyperbaric

720 N Tustin Ave Suite 100 Santa Ana, CA 92705 | Phone: 714.973.8777 | www.advantagewoundcare.org



**ORANGE COUNTY WOUND & HYPERBARIC
720 N TUSTIN AVE. STE 100
SANTA ANA, CA 92705**

Last Name: _____ **First Name:** _____

Address: _____ **Apt#** _____ **City:** _____

State: _____ **Zip Code:** _____ **Social Security #:** _____

Home Phone # (____) _____ **Cell Phone #** (____) _____

Email: _____ **Language:** _____ **Ethnicity:** _____

Date of Birth: __/__/__ **Gender:** M/F/Other **Marital Status:** S M D W

Spouse: _____ **Phone Number:** _____

Emergency Contact Name: _____ **Phone Number:** _____

Primary Care Physician Name: _____

Phone Number: _____ **Fax Number:** _____

Referring Physician Name (if different): _____ **Phone Number:** _____

Referring Home Health Agency (if any): _____ **Phone Number:** _____

In accordance with HIPAA (Health Insurance Portability and Accountability Act), we are required to institute specific confidentiality safeguards regarding your personal medical health information. By signing below, you are authorizing and acknowledging that the person listed above may be provided PHI.

SIGNATURE: _____ **DATE:** _____



**ORANGE COUNTY WOUND & HYPERBARIC
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SANTA ANA, CA 92705**

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I, the undersigned, hereby voluntarily authorize and direct _____ to provide from my medical record(s) the information specified below to:

**ORANGE COUNTY WOUND & HYPERBARIC
720 N TUSTIN AVE. STE 100
SANTA ANA, CA 92705
P (714) 973 8777 F (714) 973 8778**

The disclosure of records authorized if required for the following purposes:

- Further Medical Care Determination of Disability Insurance
 Attorney Other (Specify) _____

I understand that this medical information may not be further used or disclosed unless another authorization is obtained from me, unless such disclosure is specifically required or permitted by law. A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid as the original.

Items requested: DOS: _____ All Records H&P LAB Reports Radiology
 MRI/CT Ultrasound/Vascular OTHER _____

Print Name: _____ **Patient Signature:** _____ **Date:** _____



CONSENT FOR PHOTOGRAPHY

Clinic Location: _____ Patient Name: _____

Date of Service: _____ Physician: _____

In connection with the medical care that I am receiving through this facility, I consent that still or digital photographs may be taken of wound areas on my body, under the following conditions: the purpose of medical documentation, education, knowledge, research, and/or media publicity, which Advantage Surgical Wound Care/Orange County Wound and Hyperbaric may deem proper.

I understand that neither myself/the patient nor members of my/the patients family will be identified by name in connection with any public use of this material, nor any other identifying material be connected to these photographs that could be construed as a violation of my privacy.

I grant this consent as a voluntary contribution and I waive any and all rights I/patient may have to royalties or other compensation in connection with any such use. I confirm that I have read and fully understand the above prior to signing.

The photographs will be taken by a member of the medical care team at _____ (institution/agency), or by a designated photographer. I accept no compensation or other remuneration for the use of such photographs as I have authorized.

Signature: _____ Date: _____

Or Authorized Representative: _____ Date: _____

Reason patient cannot sign: _____

Witness:

*If subject is a minor, a consent must be obtained from parent/legal guardian

Clinician Signature: _____ Printed Clinician Name: _____

Date: _____



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INSURANCE CARDS: Please provide a current copy of your insurance cards, DL or Photo ID

FINANCIAL RESPONSIBILITY: It is my responsibility to keep Orange County Wound and Hyperbaric/Advantage Surgical Wound Care, aware of any changes or modifications to my insurance coverage. I understand and agree that (regardless of insurance status), I am ultimately responsible for the full balance of my account for the professional services I receive. I understand that I am responsible for payment of co-payments, deductibles, and supplies on the day of the service. I understand that I will be billed directly when any part of the payment of services that I have received is denied or not received within 120 days after the bill is submitted to my insurance. _____ (Initial)

CONSENT TO TREATMENT: This consent authorizes the physician or medical associate to administer, prescribe medication, provide medical treatment, perform surgical procedures, and document the treatment with photographs, videos, as needed. _____ (Initial)

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Orange County Wound and Hyperbaric/Advantage Surgical Wound Care the insurance and/or Medicare benefits to which I am entitled. I understand that I am financially responsible for charges not covered by this assignment. _____ (Initial)

MISSED AND CANCELLED APPOINTMENTS: I understand and agree that I may be charged \$25 for missed appointments or cancelled within less than 24-hour notice. _____ (Initial)

FORMS: There will be an additional \$25 charge for any form(s) such as Handicap Placard, Disability, DMV, etc. filled by the MD/PA/NP. _____ (Initial)

SUPPLIES: We may recommend supplies that may be helpful to improve your condition. When these supplies are covered by your insurance, we will submit the necessary paperwork. However, in instances when your insurance will not cover supplies, our office can provide the supplies to you at a reasonable cost and/or provide you information on where to purchase these supplies. The choice to purchase these items is yours. _____ (Initial)

INSUFFICIENT FUNDS FEE: There will be an additional \$25 fee charged for any checks that are returned to OCWH/ASWC due to insufficient funds. _____ (Initial)

PRINT NAME: _____ **SIGNATURE:** _____ **DATE:** _____



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Our Notice of Privacy Practices provides information about 1. The privacy rights of our patients; and 2. How we may use and disclose protected health information (PHI) about our patients.

Federal regulations requires that we give our patients or their authorized representatives (“You”) the opportunity to review our Notice before signing this acknowledgement. A copy of our Notice will be made available to you.

If you have any questions about your rights or our privacy practices, please send a letter to:

**ORANGE COUNTY WOUND & HYPERBARIC
ATTENTION: PRIVACY OFFICER
720 N TUSTIN AVE. STE 100
SANTA ANA, CA 92705
P (714) 973 8777 F (714) 973 8778**

We will respond to you in writing within the time allotted by HIPAA guidelines.

By signing this form, you acknowledge only that we have provided you with immediate access to our Notice of Privacy Practices.

Signature of Patient or Authorized Representative: _____ Date: _____

Print Patient Name: _____

Print Name of Authorized Representative: _____



PATIENT CONSENT FOR WOUND CARE TREATMENT

PATIENT NAME: _____ DATE OF BIRTH: _____

FACILITY: _____

Patient hereby voluntarily consents to wound care treatment (including gastrostomy tube replacement and/or cryotherapy, if applicable) by Robert Marriott Medical Corp., d/b/a Advantage Surgical and Wound Care, and their respective employees, agents, representatives, and affiliated companies (hereinafter collectively referred to as “Advantage”). 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 Advantage. Patient has the right to give or refuse consent to any proposed procedure or treatment at any time prior to its performance.

1. General Description of Wound Care Treatment: Patient acknowledges that Wound Care Provider has explained that 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 Wound Care Provider. Patient acknowledges that Wound Care Provider has given Patient the opportunity to ask, Patient has asked, and Wound Care Provider has answered all Patient’s questions regarding the wound care treatments that may be provided.

2. Benefits of Wound Care Treatment: Patient acknowledges that Wound Care Provider has explained that the benefits of wound care treatment, including enhanced wound healing and reduced risks of amputation and infection.

3. Risks/Side Effects of Wound Care Treatment: Patient acknowledges that Wound Care Provider has explained that wound care treatment may cause side effects and risks including, but not be limited to: infection, ongoing pain and inflammation, potential scarring, possible damage to blood vessels, possible damage to surrounding tissues, possible damage to organs, possible damage to nerves, bleeding, allergic reaction to topical and injected local anesthetics or skin prep solutions, removal of healthy tissue, and prolonged healing or failure to heal.

4. Likelihood of Achieving Goals: Patient acknowledges that Wound Care Provider has explained that by following the Wound Care Provider’s plan of care he or she is 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. Therefore, Patient specifically agrees that no representation made to him or her by Wound Care Provider/Advantage or constitutes a warranty or guarantee for any result or cure.

5. Alternative to Wound Care Treatment: Patient acknowledges he or she has been made aware that he or she may refuse wound care treatment and Patient acknowledges that if he or she refuses wound care treatment, he or she will not gain the benefits of treatment (see Benefits of Wound Care Treatment above). In lieu of wound care treatment by Advantage, Patient may continue a course of treatment with his or her personal Wound Care Provider or forego any treatment.

6. Benefit of Alternative to Wound Care Treatment: Patient acknowledges that Wound Care Provider has explained that if he or she chooses to continue a course of treatment with his or her personal Wound Care Provider or forego any treatment, he or she may not experience the risks/side effects associated with wound care treatment (see Risks/Side Effects of Wound Care Treatment above).

7. Risks/Side Effects of Alternative for Wound Care Treatment: Patient acknowledges that Wound Care Provider has explained that the risks of alternative wound care treatment include prolonged healing or failure to heal, infection and possible amputation if wound is on a limb.

8. General Description of Wound Debridements: Patient acknowledges that Wound Care Provider has explained that wound debridement means the removal of unhealthy tissue from a wound to promote healing. During the course of wound care treatment, multiple wound debridements may be necessary and will be performed by an authorized practitioner.

9. Risks/Side Effects of Wound Debridement: Patient acknowledges that Wound Care Provider has explained that 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, excessive bleeding, removal of healthy tissue, infection, ongoing pain and inflammation, and failure to heal. Patient specifically acknowledges that Wound Care Provider has explained that bleeding after debridement may cause rapid deterioration of an already compromised patient. Patient specifically acknowledges that Wound Care Provider has explained that drainage of an abscess or debridement of necrotic tissue may result in dissemination of bacteria and bacterial toxins into the bloodstream and thereby cause severe sepsis. Patient specifically acknowledges that Wound Care Provider has explained that debridement will make the wound larger due to the removal of necrotic (dead) tissue from the margins of the wound.

10. Gastronomy Tube Check/Replacement (if applicable): Your physician has requested that you undergo a feeding tube check and/or change to manage your feeding tube. Risks associated with the procedure include, but are not limited to, pain or discomfort at the tube insertion site, bleeding at the site, internal bleeding, injury to a blood vessel, organ puncture, and infection which may result in an infection of the blood stream. The development of any infection may result in the need for intravenous antibiotics. Patient acknowledges that if he or she refuses gastronomy tube check/replacement, he or she will not gain the benefits of treatment.

11. Cryotherapy (if applicable): Cryotherapy is a treatment that uses liquid nitrogen to remove precancers, skin tags, warts, seborrheic keratosis, and skin growths by freezing them (sometimes requiring multiple treatments). The treated skin may become red and swollen. You may develop a blister (common), scar (rare), infection (rare), temporary or permanent (rare) discoloration, or non-healing sores at treatment areas, such as the lower legs.

12. Patient Identification and Wound Images: Patient understands and consents that images (digital, film, etc.), may be taken by Wound Care Provider/Advantage of Patient and all Patient's wounds with their surrounding anatomic features. The purpose of these images is to monitor the progress of wound treatment and ensure continuity of care. Patient further agrees that their referring Wound Care Provider or other treating Wound Care Providers may receive communications, including these images, regarding Patient's treatment plan and results. The images are considered protected health information and will be handled in accordance with federal laws regarding the privacy, security and confidentiality of such information. Patient understands that Advantage will retain the ownership rights to these images, but that the patient will be allowed access to view them or obtain copies according to state and Federal law. 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 Advantage upon written authorization from the Patient or Patient's legal representative.

13. Use and Disclosure of Protected Health Information (PHI): Patient consents to Advantage'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 Advantage wound database for purposes of, education, research, quality assessment and improvement activities, and development of proprietary clinical processes and healing algorithms. Patient's PHI may be disclosed by Advantage 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 Advantage, 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 Advantage's Chief Compliance

Officer at 222 N. Pacific Coast Highway. Suite 1420, El Segundo, CA 90245. If the PHI is owned by another entity, Advantage will direct Patient's request to the appropriate party.

14. Financial Responsibility: Patient understands that regardless of his or her 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.

15. Telemedicine Consultations: Patient may choose to have a consultation done via telemedicine and the right to stop the consultation at any time. Wound Care Provider has the right to request the Patient to be seen face to face if enough Patient information cannot be obtained via telemedicine to provide a diagnosis. Photography and secure messaging may be used for telemedicine documentation.

16. Open Payments Database Patient Notification: The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>. For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars (\$10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

Patient hereby acknowledges that he or she has read and agrees to the contents of sections 1 through 16 of this Consent for Wound Care Treatment. By signing below, Patient: (1) consents to the care, treatment, and services described in this document and orally by the Wound Care Provider/Advantage, (2) consents to the creation of images to record his or her wounds and (3) consents to the transfer of health information protected by HIPAA between Wound Care Provider and Advantage.

Signature of Patient/POA

Date

If Patient/ POA cannot complete form - verbal consent obtained in person or by phone

Telephone Number: _____

Relationship to Patient: _____

Response to Consent: _____

Signature of person placing call _____

POA Documentation on File (if applicable)

Interpreter used (if applicable)

Wound Care Provider Signature

Date

Witness Signature

Date