PATIENT INFORMATION

Please fill out forms entirely

Name: _____ DOB: _____

Phone: _____ Alt Phone: _____

SSN: _____ Marital Status: _____

Address: _____

Email: _____

RACE:

- ☐ Hispanic/Latino
- ☐ Black/African American
- ☐ White
- ☐ Two or More Races
- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian/Pacific Islander
- ☐ Asian
- ☐ Decline to State

Other: _____

ETHNICITY:

☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to State

Reason for Consultation: _____

How long has wound been present?: _____

Location of Wound: _____

Previous wound care treatments: _____

Home Health Provider : _____

Pharmacy: _____ Address: _____

Referring Physician/Company: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____ Phone: _____

Allergies: _____

Social History: ☐ Current Smoker ☐ Former Smoker ☐ Never

CURRENT MEDICATIONS *(use back of page if needed):*

NAME	DOSE	FREQUENCY	TAKEN FOR

CURRENT MEDICAL PROBLEMS *(use back of page if needed):*

DIAGNOSIS	DATE OF ONSET

PAST MEDICAL PROBLEMS, HOSPITALIZATIONS OR SURGERIES *(use back of page if needed):*

DIAGNOSIS	DATE OF ONSET

Family Medical History: _____

INSURANCE INFORMATION

1. Primary Insurance Company: _____

Subscriber Name: _____

Subscriber DOB: _____ SSN: _____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Subscriber ID #: _____ Subscriber Group #: _____

2. Secondary Insurance Company: _____

Subscriber Name: _____

Subscriber DOB: _____ SSN: _____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Subscriber ID #: _____ Subscriber Group #: _____

3. Tertiary Insurance Company: _____

Subscriber Name: _____

Subscriber DOB: _____ SSN: _____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Subscriber ID #: _____ Subscriber Group #: _____

Please provide insurance card and photo identification to reception for copies

HIPPA AUTHORIZATION

I give permission for Keystone Health to RELEASE any medical information to:

Name: _____

Name: _____

The above mentioned person(s) will be required to provide photo ID when picking up items.

GENERAL CONSENT FOR CARE AND TREATMENT & CONSENT TO BILL

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 or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).*

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing.

You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

If I do not have medical insurance, I understand that I am responsible for all charges incurred and that I will be billed for any outstanding balances in accordance with Keystone Health billing policy;

If my insurance is accepted, I authorize payment of benefits to Keystone Health or will reimburse Keystone Health if I am paid directly by my carrier;

I hereby authorize that Keystone Health may furnish information concerning my illness and treatment to my insurance carrier(s) in accordance with its privacy policy;

I am advised that any tests (blood work and other specimens) sent to an outside laboratory will result in additional charges that will be billed to my insurance carrier and/or will be billed directly to me by the laboratory;

I also understand that I am responsible for any part of the charges that are not covered by my insurance and I will be billed directly for those services.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Printed Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____