r TEXOMA MEDICAL CENTER

AUTHORIZATION FOR RELEASE OF INFORMATION

1. Release information from the hospital record of:

_____ _____ x_____
Patient's Name – please print Date of Birth Social Security No.

_____ _____
Date of Treatment(s) Telephone Number

2. I hereby authorize _____ to release information to:
(sending hospital)

_____
(receiving entity)

_____
(address of receiving entity)

3. Medical Records will not be released until they are complete. (Exception: Records required for continuation of care may be released to a designated caregiver prior to completion.)
Return date of completed records (15 days).

4. Information to be released.

_____	Face Sheet	_____	Doctor's Orders	_____	Chart Abstract
_____	Emergency Room	_____	Laboratory Reports		
_____	History & Physical	_____	Radiology Reports (to date) CT chest, CXR x 2, Venous doppler		
_____	Discharge Summary	_____	EKG, EEG		
_____	Operative Report	_____	Nurse's Notes		
_____	Pathology Report	_____	Entire Chart		
_____	Doctor's Notes	_____	Other: _____		

5. I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand that the specific information to be disclosed may include but is not limited to history of DRUG or ALCOHOL ABUSE, or MENTAL HEALTH TREATMENT, or information concerning communicable diseases such as HUMAN IMMUNODEFICIENCY VIRUS (HIV) and ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), and laboratory test results, treatment progress or any other such related information.

6. Patient information is needed for:

_____	Continuing Medical Care	_____	Military	_____	Social Security / Disability
_____	Insurance	_____	Personal Use		Other: _____
_____	Legal Purposes	_____	School		_____

7. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it. This authorization will expire 180 days from the date of my signature or as otherwise specified by date, event or condition as follows: _____

8. I further authorize that a photocopy of this authorization is acceptable as an original.

9. I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. Also, I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing law.

x_____ x_____ x_____
Signature of Patient or Legal Representative Relationship to Patient Date

_____ _____ _____
Signature Acknowledgement of Receipt of Records Number of pages Date of Receipt or Transmittal of Records

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500, in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

RI0010

Conditions of Admission/Registration
Treatment Authorization and Financial Responsibility

As the individual who will be receiving services at Texoma Regional Medical Center (the "Hospital"), or the parent or guardian of the individual listed below as the patient, I agree to the following terms and conditions of this Conditions of Admission/Registration Treatment Authorization and Financial Responsibility Agreement (the "Agreement").

1. **CONSENT TO HOSPITAL PROCEDURES:** I consent to the medical and surgical procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services. These services and procedures may include but are not limited to laboratory tests, x-ray examination, newborn hearing screening, medical or surgical treatment or procedures, anesthesia, or Hospital services rendered under the general and special instructions of a physician. This general consent does not apply to any procedures which require informed consent as described by Title 25, Chapter 601of the Texas Administrative Code.

2. **RELEASE OF INFORMATION:** I authorize the Hospital, physicians, and other licensed providers furnishing these services to disclose my Protected Health Information ("PHI") as that term is defined by the federal law referred to as "HIPAA" for purposes of treatment, payment and health care operations to third parties including but not limited to insurance carriers, health plans (including government health programs such as Medicare and Medicaid), or workman's compensation carriers that may be responsible for payment of the services ("Third Party Payors"). The PHI disclosed may include information about my treatment, medical care, medical history, billing information, and other information received or acquired by the Hospital and maintained in any form, including written, oral or electronically maintained information.

   Upon inquiry the Hospital will describe my condition to callers or the public using one of the following words; undetermined, good, fair, serious, or critical. If I do not want this information released I may make a written request for information about my condition to be withheld. I understand I can request a separate form to make this change.

3. **PROVIDERS NOT HOSPITAL EMPLOYEES:** I understand that the physicians furnishing services to me including Hospital-based physicians such as radiologists, pathologists, emergency department physicians, and anesthesiologists ("Hospital-Based Physicians") are independent contractors and are not employees or agents of the Hospital.

4. **HOSPITAL, PHYSICIAN, AND PRACTITIONER BILLING:** I understand that each physician, medical group, or other practitioner who provides professional services to me while I am in the Hospital, including Hospital-Based Physicians (collectively "Practitioners"), will bill and collect for their professional services separate and apart from the Hospital. This Agreement applies to services rendered by the Practitioners as well as the Hospital. I also understand I have the right to request an explanation of the Hospital billing process and a list of the Hospital's charges for any services I might receive.

5. ASSIGNMENT OF BENEFITS AND RIGHT OF ACTION. In return for services to be furnished, I make the following irrevocable assignments to the Hospital:

a. **Assignment of Health Insurance Benefits**. I irrevocably assign to the Hospital and other Healthcare Providers/Practitioners who furnish services to me all benefits payable for services rendered to me by each party payable by a Third Party Payor, including without limitation a health insurance company, health plan, worker's compensation program, ERISA plan, or any other entity responsible for payment of patient's hospital bill. This assignment extends to the total amount of the Hospital's bills, with interest as allowed by law.

b. **Assignment of Personal Injury Proceeds.** I assign and transfer my right to receive benefits payable to me under the policies described below to the Hospital and Practitioners involved in my care. The policies may include benefits payable under Personal Injury Protection, Medical Pay, Uninsured/Underinsured, and/or liability provisions of any insurance policy under which I am entitled to receive benefits related to the occurrence that caused or contributed to the injuries or condition being treated by the Hospital or the Practitioners. I understand and acknowledge that this assignment includes the total amount of my Hospital bill(s), including interest as allowed by law.

c. **Assignment of Claims and Right of Action.** I understand that this assignment of benefits gives the Hospital and Practitioners the right to be paid directly by my Third Party Payor for the services provided to me or the individual designated below as the patient for this admission. In return for the services furnished by the Hospital and Practitioners, I assign and transfer to these parties all right, title, and interest in all benefits payable for the health care rendered, which are provided in under insurance policies and health benefit plans for which my dependents or I are entitled to recover. This assignment and transfer shall be for the purposes of granting the Hospital and Practitioners an independent right of recovery against my Third Party Payor, but shall not be construed as an obligation of these parties to pursue any such right or recovery. In no event will the Hospital or Practitioners have any right to retain benefits in excess of the amount owed to them for the care and treatment rendered during this admission.

d. **Secondary Payors.** I understand that any health insurance policies under which I am covered are secondary payers to any existing liability policies or any other sources of payment that may or will cover expenses incurred for services and treatment.

e. **Appointment of Agent.** I appoint the Hospital, the Practitioners, and any agent acting on their behalf as my authorized representative to pursue any claims, penalties, and administrative and/or legal remedies on my behalf for collection against any responsible Third Party Payor or third party liability carrier of any and all benefits due me for the payment of charges associated with my treatment.

I have read and been given the opportunity to ask questions about this assignment of benefits, and I have signed this document freely and without inducement, other than the rendition of services by the Hospital, Hospital-Based Physicians, and other affiliated physicians and health care practitioners.

6. FINANCIAL AGREEMENT: I agree, whether signing as a parent, guarantor, agent or the patient, that in consideration of the services provided by the Hospital, I will promptly pay all Hospital bills in accordance with the Hospital's standard charges for such services, and, if applicable, the Hospital's charity care and discount payment policies, as well as in accordance with applicable and state and federal law. Should my account be referred to an attorney or collection agency for collection, I will pay actual attorney's fees and collection expenses. I understand that all delinquent accounts may be charged interest at the legal rate.

I certify that the information I have provided is true and accurate to the best of my knowledge. I understand that the information I submit is subject to verification, including credit agency scoring, and subject to review by federal and/or state agencies and others as required. I authorize my employer to release proof of my income to the Hospital if requested. I understand that if any information I have given proves to be untrue, the Hospital may re-evaluate my financial status and take whatever action becomes appropriate.

7. NOTICE OF NETWORK STATUS. In accordance with Senate Bill 1731 the Hospital is required to inform you:

- If the Hospital is a participating provider ("In Network") under your health plan based on the information that you provide to the Hospital;
- Physicians and other health care providers who may provide services to you while in the Hospital may not be participating providers (or In Network) with the same health plans as the Hospital, and as such, you may be responsible for out of network copayments or deductibles charged by your health plan;
- You may request an estimate of the Hospital's charges for any service or supply;
- The Hospital must provide an itemized statements of billed services within 10 days of your request;
- Any overpayments for services received by the Hospital will be applied to any other open accounts under your name or refunded to you within 30 days; and
- Written policies for billing of Hospital services and supplies are available upon request. For complaints relating to the charges for Hospital services and supplies please call: (866) 880-6470.

8. **CHARITY CARE AND DISCOUNTED PAYMENTS:** If you do not have health insurance, you may qualify for financial assistance. If you think you may be eligible for financial assistance to help with payment of your Hospital bills, please call:

   Hospital Financial Counselor: (903) 416-4164 or

   Central Billing Office: (866) 880-6470

9. **AUTHORIZATION FOR RECEIVING MESSAGES AND AUTOMATED CALLS:** I give the Hospital (including its agents and third party collection agents) permission to contact me by telephone at the telephone number or numbers I provided during the registration process, or at any time in the future, including wireless telephone numbers or other numbers that may result in charges to me. The Hospital and its agents may leave messages for me at these numbers and may send text messages or email communications using the email address or addresses I provide. These voice messages and email and text communications may include information required by law (including debt collection laws) related to amounts I owe the Hospital as well as messages related to my continued care and treatment.

   I also understand that the Hospital and its agents, including debt collection agencies, may use pre-recorded/artificial voice messages and/or use an automatic dialing devise (an autodialer) to deliver messages related to my account and amounts I may owe the Hospital. I also authorize the Hospital and its agents to use the number or numbers provided for such pre-recorded or auto dial messages. If I want to limit these communications to a specific telephone number or numbers, I understand that I must request that only a designated number or numbers may be used for these purposes.

10. **MEDICARE CERTIFICATION, AUTHORIZATION TO RELEASE PAYMENT INFORMATION AND PAYMENT REQUEST:** I certify that any information given by me in applying for payment under title XVIII of the Social Security Act (Medicare) is correct. If applicable, I authorize the Hospital, Hospital Based Physicians or any other health care providers who have medical or other information about me to release any information needed for this or a related Medicare claim to the Social Security Administration or its intermediaries or carriers. I request that payment of authorized benefits be made on my behalf.

11. **GENERAL DUTY NURSING:** I understand that the Hospital provides only general duty nursing care unless my physician orders more intensive nursing care. If my condition requires a special duty nurse, I understand that it must be arranged by me or my legal representative. The Hospital is not responsible for providing or paying for such special duty nurses.

Patient Identification

DOB:
MRN:

SX:

12. **PRIVATE ROOM:** I understand and agree that if the Hospital assigns me to a semi-private room but I request and receive a private room, I am responsible for any additional charges associated with the private room. Any extra changes for a private room do not apply if the Hospital assigns me to a private room independently of any request by me.

13. **BLOOD AND OTHER BODILY FLUID TESTING:** I understand and acknowledge that if any healthcare worker is exposed to my blood or other bodily fluid, Texas law permits the Hospital to perform tests on my blood or other bodily fluids, with or without my consent, to determine the presence of any communicable disease, including but not limited to Hepatitis, HIV/AIDS and Syphilis. I understand that the results of tests taken under these circumstances are confidential and do not become part of my medical record.

14. **PERSONAL VALUABLES:** I understand that the Hospital maintains a safe for the safekeeping of money and other valuables, and that the Hospital is not liable for the loss of my valuables unless they are deposited with the Hospital for safekeeping. I understand that I am responsible for all my personal effects not deposited in the safe, including, but not limited to, personal grooming articles, jewelry, clothing, documents, medications, eye glasses, hearing aids, dentures and other prosthetic devices.

15. **ASSUMPTION OF RISK:** If I leave the Hospital before being released or discharged by my physician, or if I fail to follow instructions given to me by my physician or other healthcare professionals, I agree to assume all responsibility for any injury or damages suffered, and further agree to release and hold the physicians, their agents, the Hospital, it's employee's or agents harmless from any claims, demands or suits for damages from any complications associated with such actions.

16. **PHOTOGRAPHY AND FILMING FOR PURPOSES OF DIAGNOSIS, IDENTIFICATION AND TREATMENT:** I consent to the taking of pictures for purposes of identification and treatment of my condition or disease.

17. **DISPOSAL OF MEDICAL RECORDS. I understand that Texas law permits this Hospital to dispose of my medical records as follows:**

    1. On or after the 10th anniversary of the date on which I was treated in the Hospital;

    2. For patients younger than 18 years of age when last treated, the Hospital may dispose of the records on or after the patient's 20th birthday, or on or after the 10th anniversary of the date on which the patient was last treated, whichever date is later;

    3. The Hospital may not destroy medical records that relate to any matter that is involved in litigation if the Hospital knows the litigation has not been resolved.

18. **NON SMOKING CAMPUS:** I understand that smoking is not permitted on the campus of the Hospital, except in designated areas and I agree to comply accordingly.

By signing below, I acknowledge that I have received a copy of the "Patient's Bill of Rights" and "Patient Responsibilities"; I have also carefully read and fully understand this Agreement and received a copy for my records, I accept its terms, and am authorized to execute the Agreement.

PATIENT/PARENT/GUARDIAN SIGNATURE	**DATE / TIME**
RELATIONSHIP IF NOT PATIENT SIGNATURE	**DATE / TIME**
REASON PATIENT DID NOT SIGN	**DATE / TIME**

Patient Identification

DOB:
MRN:

SX:

TEXOMA MEDICAL CENTER
TMC Center for Wound Healing and Hyperbaric Medicine

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* 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: debridement, 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 forgo 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 débridements 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.

TEXOMA MEDICAL CENTER
TMC Center for Wound Healing and Hyperbaric Medicine

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 the 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

TEXOMA MEDICAL CENTER
TMC Center for Wound Healing and Hyperbaric Medicine

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 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 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 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 services** 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, may 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 a.m. and 4:30 p.m. (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.

TEXOMA MEDICAL CENTER
TMC Center for Wound Healing and Hyperbaric Medicine

PATIENT HISTORY

GENERAL INFORMATION		DATE:	
Name:		Home Phone:	
Address:		Cell Phone:	
City:		State:	Zip:
▲ E-mail:	Date of Birth:	Age:	Sex:

SOCIAL HISTORY

Do you live alone: ☐ No ☐ Yes	Do you drive: ☐ No ☐ Yes	Employed: ☐ No ☐ Yes	
What is the highest school grade you completed? ☐ 1-6 ☐ 7-9 ☐ 10 ☐ 11 ☐ 12 ☐ Some college ☐ College graduate			
Marital Status: ☐ Separated ☐ Divorced ☐ Married ☐ Single ☐ Widowed			
Do you smoke: ☐ No ☐ Yes If Yes, for how many years:	How many packs per day:	If quit, when:	
Do you drink alcohol: ☐ No History ☐ Prior History ☐ Current History		Type:	
Do you use recreational drugs: ☐ No ☐ Yes If Yes, amount:		Type:	
Caffeine Use: ☐ No ☐ Yes If Yes, for how many years:	How many cups per day:		
Financial Concerns: ☐ No ☐ Yes	Food / Clothing / Shelter Needs: ☐ No ☐ Yes		
Support System Intact: ☐ No ☐ Yes	Transportation Concerns: ☐ No ☐ Yes		

Emergency Contact Information

Name:	Home Phone:
Relationship:	Cell Phone:

What physician suggested you visit the Wound Healing Center®?

Name:	Specialty:	Phone:	
Address:	City:	State:	Zip:

Who is your primary physician?

Name:	Specialty:	Phone:	
Address:	City:	State:	Zip:

Please provide contact information (if applicable):

Home Health Agency:	Phone:
Nursing Home/Skilled Nursing Facility:	Phone:
Pharmacy:	Phone:

Do you have any of the following?

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

*Copy required for chart: Requested by: _____ Date: _____ Time: _____
☐Copy provided: Signature: _____ Date: _____ Time: _____

Name of person completing form: _____ Relationship to patient: _____

Signature: _____ Date: _____ Time: _____

Reviewed by: _____ Date: _____ Time: _____

1HP

TEXOMA MEDICAL CENTER
TMC Center for Wound Healing and Hyperbaric Medicine

PATIENT HISTORY

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? ☐ Bite ☐ Blister ☐ Bruise ☐ Bump ☐ Chemical burn ☐ Footwear ☐ Frostbite ☐ Gradually appeared ☐ Not known ☐ Other lesion ☐ Pimple ☐ Pressure ☐ Radiation burn ☐ Surgical ☐ Thermal burn ☐ Trauma		
How have you been treating your wound until now?		
Have you had any lab work down in the past month? ☐ No ☐ Yes	If yes, who ordered?	
Have you ever had bacteria that resisted antibiotics? ☐ No ☐ Yes		If yes, date:
Have you ever had a bone infection? ☐ No ☐ Yes		If yes, date:
Have you had any tests for blood flow in your legs? ☐ No ☐ Yes		If yes, date:
If yes, where was it done:	Who ordered?	
Have you had any other problems with your wound? ☐ Infection ☐ Swelling ☐ Other:		

PATIENT'S MEDICAL HISTORY (Please check Yes or No for each item)

	Yes	No		Yes	No
Cataracts (Cloudy vision)			Cirrhosis (Liver problems)		
Glaucoma (Eye disease)			Colitis / Crohn's (Bowel problems)		
Chronic Sinus problems / congestion			Hepatitis (Type:)		
Middle ear problems			Thyroid Disease		
Ear Surgery			Type I Diabetes		
Anemia (Tired, or low iron)			Type II Diabetes		
Hemophilia (Bleeding disorder)			End Stage Renal Disease (Kidney Disease)		
Human Immunodeficiency Virus (HIV)			On Dialysis (Type: _____)		
Lymphedema (Swelling in legs or arms)			Lupus (Problem with your immune system)		
Sickle Cell Disease			Raynaud's Syndrome (Problem with blood flow to your fingers or toes)		
Aspiration			Scleroderma (Skin disorder)		
Asthma (Breathing problem)			Rheumatoid Arthritis (Swelling of joints)		
Chronic Obstructive Pulmonary Disease (COPD)			History of Burn		
Pneumothorax (Collapsed lung)			Gout (Pain in big toes)		
Sleep Apnea (stop breathing when sleeping)			Osteoarthritis (Pain in bones or joints)		
Tuberculosis (infection in the lungs)			Dementia (Memory loss that gets worse over time)		
Angina (Chest pain)			Neuropathy (Numbness in hands or feet)		
Arrhythmia (Skipped heartbeat)			Paraplegia (Can't move arms or legs)		
Atrial Fibrillation (Rapid heart rate)			Quadriplegia (Can't move arms and legs)		
Congestive Heart Failure			Received Chemotherapy		
Coronary Artery Disease (Heart disease)					
Deep Vein Thrombosis (Blood clot in leg)			Surgery		
Hypertension (High blood pressure)			Anorexia / bulimia		
Hypotension (Low blood pressure)			Confinement Anxiety (Fear about being in a closed space)		
Myocardial infarction (Heart attack)					
Peripheral Arterial Disease (Problem with blood flow in your legs)			Peripheral Venous Disease (Problems with blood vessels in your legs)		
Vasculitis (Inflammation of your blood vessels)			Phlebitis (Inflammation of the veins in your legs)		

FAMILY MEDICAL HISTORY (Please indicate with a checkmark if any of your family members have / had this condition)

Name of person completing form: _____ Relationship to patient: _____
Signature: _____ Date: _____ Time: _____

Reviewed by: _____ Date: _____ Time: _____
Reviewed by: _____ Date: _____ Time: _____

TEXOMA MEDICAL CENTER
TMC Center for Wound Healing and Hyperbaric Medicine

PATIENT HISTORY

HOSPITALIZATION / SURGERY HISTORY (Please list all)

Condition	Maternal Grandparents	Paternal Grandparents	Mother	Father	Siblings
Cancer					
Diabetes					
Heart Disease					
Hypertension					
Kidney Disease					
Lung Disease					
Seizures					
Stroke					
Tuberculosis					

NAME OF HOSPITAL	REASON YOU WERE IN THE HOSPITAL	DATE

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.

For Healthcare Practitioner Use Only

NOTES:

Name of person completing form: _____ Relationship to patient: _____
Signature: _____ Date: _____ Time: _____

Reviewed by: _____ Date: _____ Time: _____
Reviewed by: _____ Date: _____ Time: _____