Charleston Wound Care

180 Wingo Way, Suite 101
Mount Pleasant, SC 29464
Phone (843) 800-1215
Fax: (843) 284-9860

1525 Ashley River Road, Ste A
Charleston, SC 29407
Phone (843) 612-5350
Fax(843) 948-6208

1229 Nexton Parkway, Unit A
Summerville, SC 29486
Phone: (843) 585-3577
Fax: (843) 585-3578

Patient Information

Full Name: _____ **MI:** ____

Date of Birth: ____ / ____ / _____ **Age:** _____ **Sex:** ☐ M ☐ F

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

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

Home Phone: _____
Cell Phone: _____
Email: _____
Social Security #: _____
Occupation: _____ **Work Phone number** _____

Emergency Contact: _____
Relationship: _____
Phone: _____

Preferred Pharmacy: _____
Pharmacy Address: _____

Appointment Reminder Preference:
☐ Phone/Voicemail ☐ Text Message ☐ None

Authorized Persons to Discuss My Medical Care:
Name: _____ Relationship: _____

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Insurance & Payment Authorization

- I agree to pay all charges at the time of service, including copays and deductibles.
- I authorize the release of medical and insurance information as required.
- I accept responsibility for any outstanding account balance. In the event of non-payments, your account will be forwarded to a collection agency and you will be responsible for all collection fees, court costs and attorney fees.
- I understand that failure to notify Charleston Wound Care of insurance changes may result in personal responsibility for charges incurred.

Patient Signature: _____ **Date:** _____

Patient Treatment Agreement

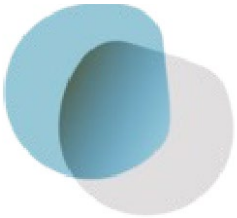
I understand that I am being seen for treatment in order to achieve the healing of my wound(s). This treatment is known to be effective only when provided on a regular basis. Missed appointments, sporadic appointment attendance or failure to comply with the plan of care presented by my physician can result in less effective or infective therapy. Thus, I understand that in order for my treatment to be successful, it is important that I receive treatment as scheduled and follow the treatment instructions provided by Charleston Wound Care.

- I will attend appointments as scheduled and provide 24-hour notice for changes.
- I understand 3 missed appointments without notice may result in discharge.
- I agree to follow the physician's treatment plan and request assistance if needed.
- I will pay a $50 fee for missed appointments without proper notice.
- I agree to follow prescribed wound care instructions and lifestyle recommendations.
- I will notify Charleston Wound Care of any insurance updates immediately.

I understand that failure to comply with these conditions may result in discharge.

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____



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CONSENT FOR PHOTGRAPHY

I hereby authorize and consent for photographs of me and/or my wound to be taken while I am a patient at Charleston Wound Care. I understand that the photographs may be taken by my attending physician or any employee of Charleston Wound Care. I further understand that such photographs may be used for the assessment and evaluation of my wound as well as educational purposes and may be published, shown, exhibited or otherwise used by Charleston Wound Care as they deem proper. I hereby consent to such use of photographs and release Charleston Wound Care, my physician and employees of Charleston Wound Care from all liability related to the taking and use of such photographs.

Patient Signature_____ Date_____

Witness Signature_____ Date_____

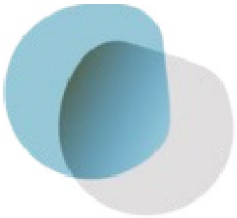
When the patient is a minor or otherwise legally incompetent, the legal guardian has the authority to authorize medical services. However, any minor patient who can understand this form should be given the opportunity to sign it in addition to the legal representative.

Signature of Legal Representative_____ Date_____
Relationship to Patient: _____
Witness Signature_____ Date_____

Procedure Consent

I consent to treatment by Charleston Wound Care, including but not limited to:

- Wound debridement
- Dressing changes
- Compression therapy
- Biopsies
- Skin substitutes
- Imaging and lab work
- Medication administration



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- I understand the risks, benefits, and alternatives of treatment.
- I consent to use of anesthetics as needed.
- I understand no guarantees have been made.
- I may revoke this consent at any time, except where already relied upon.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Medicare Authorization

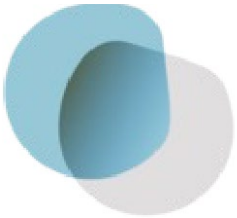
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Charleston Wound Care for any services rendered for me by the physician(s). I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or benefits payable for rendered services.

Signature: _____ Date: _____

Medicare Secondary Insurance

I understand that my secondary claim is billed as a courtesy only and will be submitted to the appropriate party ONE TIME. After that one-time submission if the insurance company does not pay within 60 days or denies the claim; (the patient) will be financially responsible to pay remaining balance.

Signature: _____ Date: _____



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HIPAA Privacy Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct a plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payors
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used to disclosed to carry out treatment, payments, or health care operations. I also understand you are not required to agree to my requested, but if you do agree then you are bound to abide by such restrictions.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had that opportunity to read if I choose) and understand the Notice.

Signature: _____ Date: _____

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Patient name: _____

MEDICATION LIST

Name:	Dosage:	Frequency: