Curelogics
Wound Care & Hyperbaric Center

809 Highway 466
Suite 201-C
Lady Lake, Florida 32159

Phone: 352-775-2055
Fax: 352-775-6243

Patient Demographics

Name: _____ Date of Birth: _____
(Last) (first) (M.I.)

Address: _____
(street) (City) (State) (Zip)

Home Phone: _____ Cell: _____ Work: _____

E-mail Address: _____ Employer: _____

SSN: _____-_____-_____ Sex: ☐ Male ☐ Female ☐ Decline to answer

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Other

Race: ☐ African American/Black ☐ American Indian ☐ Asian ☐ Caucasian/White ☐ Hispanic
☐ Pacific Islander ☐ Other ☐ Decline to answer

Preferred Language: _____

Emergency Contact: _____ Contact Number: _____

Relation to Patient: _____ May we discuss patient information with them? ☐ yes ☐ No

How did you hear about us? _____

PRIMARY INSURANCE

Name: _____

Policy ID #: _____

Subscriber Name: _____

Subscriber DOB: _____

SECONDARY INSURANCE

Name: _____

Policy ID #: _____

Subscriber Name: _____

Subscriber DOB: _____

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Medical Questionnaire

Name: _____ Date of Birth: _____

Reason for your visit today: _____

How long has this been a concern: _____ Allergies: ☐ yes ☐ No

If yes please list: _____

List of your current Physicians and what conditions you are being treated for:

_____ _____
_____ _____
_____ _____
_____ _____

What Pharmacy do you use: _____
(name) (Phone Number)

Please list all current medical conditions: _____

Please List or attach a copy of your medications, strength, and amount:

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Assignment of Benefits

I hereby authorize Curelogics Wound Care & Hyperbaric Center to release and/or obtain any information necessary to process insurance claims for services rendered to me or my dependent. I also authorize benefits to be paid directly to Curelogics Wound Care & Hyperbaric Center. I understand that I will be responsible for co-pays, deductibles and any balances remaining after insurance has paid or deemed the claim to be "patient responsibility".

_____ _____

Patient or Responsible Party Signature Date

Authorization

I, _____, hereby

authorize _____, relationship _____

Address_____

Home phone _____ Cell phone _____

to inquire about, receive and/or provide pertinent medical information from or for Curelogics wound Care & Hyperbaric Center in case of emergency or incapacity.
I am aware that according to HIPPA and other privacy regulations only the person(s) designated above may have access to information concerning my diagnosis, treatment and/or care under Curelogics Wound Care & Hyperbaric Center.

_____ _____

Patient or Responsible Party signature Date

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MEDICAL RECORDS RELEASE

Information Request from: _____ Phone: _____ Fax: _____

Patient Name:	Sex:
Address:	
City/State/Zip:	
Telephone:	
Date of Birth:	

In reference to the above named patient, please FAX/MAIL to our office the following requested information:

- ☐ All records
- ☐ Most recent office notes
- ☐ Labs
- ☐ Imaging
- ☐ Diagnostic testing
- ☐ Other _____

Patient authorization for Release of Information to or from Curelogics Wound Care & Hyperbaric Center by Fax and/or US Mail

I hereby authorize Curelogics wound Care & Hyperbaric Center to receive and to send by FAX and/or US MAIL all pertinent requested medical information. I release and hold harmless Curelogics Wound Care & Hyperbaric Center, its members and employees, for all liability including for negligence that may arise from complying with this authorization. This authorization will be valid for five (5) years from the date of my signature.

_____ _____

Patient/Guardian Signature Date

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NOTICE OF PRIVACY PRACTICES, AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION, AND CONSENT AND AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Protected Patient Health Information

Under Federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other uses and disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes: Required by law: We may be required by law to report gunshot wounds, suspected abuse of neglect, or similar injuries and events; Research: We may use of disclose information for approved medical research. We may ask you if you would like to participate in medical research. Public Health Activities: As required by law, we may disclose vital statistics, disease, information related to recalls of dangerous products and similar information to public health authorities. Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs and similar activities. Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order; Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials; Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious health threat to your health and safety or the health and safety of the public or another person; Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes; Workers' Compensation: We may release information about you for workers' compensation or similar programs providing benefits for work-related injuries or illness. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights; Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions; Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments; Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. All requests must be in writing and signed by you or your representative. You may be charged a fee of $1.00 per page for a copy of the information and a charge for postage if you request a mailed copy. You may obtain a Request for Access Form from the Privacy Officer. We will respond within 30 days unless an extension is taken. In certain circumstances, you may not be permitted access. Depending on the circumstances, you may request a review of the decision to deny access. If we deny your request you will be given written notice that will explain the basis and your right to appeal; Amend Information: You have the right to request that your health information be amended or corrected. We will respond within 60 days unless an extension is taken. In certain cases we may deny your request for amendment and you will be given written notice that will explain the basis and your right to appeal, which will be appended to your health information. You may also submit a statement of disagreement and we may prepare a rebuttal that will be provided you. All amendment requests must be in writing, signed by you or our representative and must state the reasons for the amendment. If we make an amendment, we may notify others who work with us and have copies of the un-amended record if we believe that such notification is necessary. You may obtain a Request for Amendment Form from the Privacy Officer.

Accounting for Disclosures of Individual Health Information

You have the right to receive an accounting of certain disclosures of your health information made by us. Requests must be made in writing and signed by you or your representative. Request for Accounting Forms are available from the Privacy Officer. The right to receive this information is subject to certain exceptions, restrictions and limitations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding Protected Health Information and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post a new Notice in the waiting area and each exam room. You can also request a copy of our Notice at any time. For more information about our privacy practices contact the person listed below.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with the decision we made about your records, you may contact the person listed below. You may also send a written complaint to the U.S. Dept. of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint. Contact Person: Privacy Officer, 809 Hwy 466, Suite 201C, Lady Lake, Fl., 32159.

Patient Consent for Use and Disclosure of Protected Health Information

By my execution of this document, I hereby give my consent to Curelogics Wound Care & Hyperbaric Center employees and representatives to use and disclose my Protected Health Information in order to carry out treatment, medical research, payment, and healthcare operations. I also consent to Curelogics wound Care & Hyperbaric Center employees and representatives to mail, fax and telephone my home, other physicians, laboratories or other designated locations, as well as leave messages by voicemail, or to persons answering telephones in reference to any matters that assist the practice, in order to carry out treatment, payment, healthcare operations, appointment reminders and patient statements concerning my Protected Health Information. I agree to hold harmless Curelogics Wound Care & Hyperbaric Center and representatives for all liability, including for negligence, that may arise from disclosing my Protected Health Information as required in the daily operations of the medical practice as listed above, unless otherwise stated below. I acknowledge by my signature below that I have received a copy of this Notice of Privacy Practices and Consent for Disclosure of Protected Health Information. By my execution of this Notice, I acknowledge that if I am, or was unable to read this document, I was assisted in doing so by an employee of Curelogics Wound Care & Hyperbaric Center. This Notice is valid for 6 years from the date of my signature below.

_____
Please Print Name

_____ _____
Please Sign (or signature of Authorized Representative) Date

Your signature above acknowledges you agree to abide by the terms and conditions of our office policies and procedures as stated above as well as all Federal HIPAA guidelines.

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CONSENT TO WOUND CARE TREATMENT

Patient Name: _____ Date of Birth: _____

Physician Name: _____

The Patient hereby acknowledges that he/she has read or had this read to them and agrees to the contents of this document. Patient agrees that his/her medical condition has been explained to them by the physician. Patient agrees that the risks, benefits, alternatives of all care, treatment and services that patient will undergo have been discussed with the patient by the physician. Patient understands the nature of his/her medical condition, the risks, alternatives and benefits of treatment, and the consequences of failure to seek or delay treatment for any conditions. The patient has had the opportunity to ask questions of the physician and has received answers to all of his/her questions.

By signing below, I understand it constitutes acknowledgment that a physician has satisfactorily explained the care I will be receiving, and I have all the information I need to consent to care. I grant permission to take medical photographs of my wound or injury for record keeping purposes. I authorize release of photographs and correspondence to my referring physician for continuity of care. I consent to the transfer of health information protected by HIPAA for purposes related to treatment, payment and health care operations. These photographs shall remain a permanent part of my patient record and will not be reproduced or published for any other reason than reasons referenced above.

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/or services at the practice. A new consent will be obtained when a patient is discharged from the practice and returns for care, treatment or services.

_____ _____
Patient or representative signature Date

_____
Printed name

_____ _____
Witness signature Date

_____
Printed name of witness

The undersigned physician has explained to the patient and/or representative the nature of the treatment, reasonable alternatives, benefits, risks, side effects, likelihood of achieving goals, complications and consequences which are/or may be associated with treatment or procedure.

_____ _____
Physician signature Date