ADVANCED MOBILE WOUND CARE

56 Pointe Circle
Greenville, SC 29615
888-45-WOUND
www.advancedmobilewoundcaresc.com

New Patient Application

Patient Demographic Information

Legal Name: _____ Preferred Name: _____

DOB: _____/_____/_____ Check one: □ Male □ Female SS#/SIN: _____-_____-_____

Check appropriate Box: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated

Home phone: _____ Cell Phone: _____

Email: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Facility Name (if applicable): _____

Mailing Address (if different): _____ City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

Does the patient have a **POA (Power of Attorney)**? □ Yes □ No If yes, please provide a copy

Is the patient a minor? □ Yes □ No If yes, name of parent/guarantor completing this form: _____

Clinical Care Partners and Referral nformation

Reason for visit: _____

Is today's visit due to **WORKERS' COMPENSATION** injury? □ Yes □ No If yes, please provide Case Mgr. Information

Is today's visit due to **MOTOR VEHICLE ACCIDENT** or personal injury caused from a third party? □ Yes □ No

Does the Patient have a **DNR (Do Not Resuscitate) Order**? □ Yes □ No If yes, please provide a copy

Referring Provider: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Home Health Service: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

Billing Information

Do you have any Medical insurance? □ Yes □ No If yes, complete the following:

PRIMARY HEALTH INSURANCE INFORMATION

Insurance Company: _____ ID # _____ Group # _____

Name of Insured (if not Patient): _____ Relationship to patient: _____

Insured Birthdate: ___/___/_____ If Employer-Sponsored, Name of Employer: _____

SECONDARY HEALTH INSURANCE INFORMATION

Insurance Company: _____ ID # _____ Group # _____

Name of Insured (if not Patient): _____ Relationship to patient: _____

Insured Birthdate: ___/___/_____ If Employer-Sponsored, Name of Employer: _____

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Financial Agreement

Note: We wish to stress that the financial responsibility for services rendered rests with the patient and his/her family, regardless of any insurance coverage. Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claim. If it is not paid, the insurance company should explain to you why it was rejected. Most of the time our fees fall within their "usual and customary" guidelines; however, the responsibility for the balance of this account falls on you. If any overpayment is received it will be refunded to you. Should your account become 90 days past due, it may be sent to collections, per our discretion, and a 24% collections cost charge may be applied to your account.

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS AS WELL AS AN APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay Advanced Mobile Wound Care, LLC and New Life Health, LLC as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided.

I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been or will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I agree to reimburse ACS any collection agency fees, which may be based on a percentage at a maximum of 24% of the debt, and all costs and expenses, including reasonable attorney's fees, Healthcare provider incurs in such collection efforts.

I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator.

I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan of this document is to be considered as valid and is enforceable as the original.

Patient Name: _____ DOB: _____

Patient (or Guardian) signature: _____ Date: _____

Witness: _____ Date: _____

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow ***Advanced Mobile Wound Care, LLC and New Life Health, LLC*** operating in Greenville, SC to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment. As a second example, the patient agrees to allow this office to coordinate care provided here with the patient's primary care physician.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office by phone, mail, text and/or social media. You may choose to opt-out of any marketing or fundraising communications at any time by written request to the office.
6. If you are sending us any personally identifiable information, you should use our encrypted email system only. Please request access to this from our team. If you choose to send anything by regular email you understand that that system may not be fully secure and HIPAA compliant.
7. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
8. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
9. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
10. This notice is effective on the date stated below.
11. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the doctor has the right to refuse to give care.

Patient Name: _____ DOB: _____

Patient (or Guardian) signature: _____ Date: _____

Witness: _____ Date: _____

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Informed Consent for Medical Examination and Treatment

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, medical services, and surgical or diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered or approved by my attending physician(s), or any healthcare professional assigned to my care by my attending physician(s), and I acknowledge and consent to the following:

1. During the course of my care and treatment, I understand that various types of examinations, tests, diagnostic or treatment procedures ("procedures") may be necessary. These procedures may be performed by physician(s), physical therapist(s), chiropractor(s), nurses, technicians, nurse practitioners, or other healthcare professionals. While routinely performed without incident, there may be material risks associated with these procedures. If I have any questions concerning these procedures, I will ask my physician(s) to provide me with additional information. I also understand my physician may ask me to sign additional Informed Consent documents relating to specific procedures.
2. NO GUARANTEE OF RESULTS: Advanced Mobile Wound Care physicians and healthcare professionals cannot guarantee any specific result(s) of any examination, treatment, procedure or medical care.
3. I understand that I can change my mind regarding the procedure or treatment. If I do, I must tell the person or the team doing the procedure or treatment *before* they start.
4. I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making.
5. I understand that the clinic, as required by law, must report certain diseases to local and state agencies.
6. I understand that students and others may observe the procedure or treatment for educational purposes. Observers must be approved by this facility.

By signing this document, I certify that I have read and understand its contents and that information provided by me is accurate and complete (including insurance information and current eligibility for benefits). A copy of this document may be utilized the same as the original.

Patient Name: _____ DOB: _____

Patient (or Guardian) signature: _____ Date: _____

Witness: _____ Date: _____

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Informed Consent for Wound Care Treatment

Patient Name: _____ DOB: _____

Patient hereby voluntarily consents to wound care treatment by provider at Advanced Mobile Wound Care, LLC and New Life Health, LLC 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 the 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.

1. General Description of Wound Care Treatment: Patient acknowledges that provider has explained that treatment in the WCC 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, hyperbaric oxygen therapy, other imaging studies and administration of medications prescribed by a provider. Patient acknowledges that provider has given Patient the opportunity to ask, Patient has asked, and provider has answered all Patient's questions regarding the treatments that may be provided in the WCC

2. Benefits of Wound Care Treatment: Patient acknowledges that the provider has explained that the benefits of treatment in the WCC include: enhanced wound healing and reduced risks of amputation and infection.

3. Risks/Side Effects of Wound Care Treatment: Patient acknowledges that provider has explained that treatment in the WCC 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 provider has explained that by following the 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 the provider, clinic or WCC 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 treatment in the WCC. Patient acknowledges that if he or she refuses treatment in the WCC, he or she will not gain the benefits of treatment (see Benefits of Wound Care Treatment above). In lieu of treatment in the WCC, Patient may continue a course of treatment with his or her personal provider or forgo any treatment.

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

7. Risks/Side Effects of Alternative for Wound Care Treatment: Patient acknowledges that the 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 the provider has explained that wound debridement means the removal of unhealthy tissue from a wound to promote healing. During the course of treatment in the WCC, multiple wound debridements may be necessary and will be performed by an authorized practitioner.

9. Risks/Side Effects of Wound Debridement: Patient acknowledges that 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 the provider has explained that bleeding after debridement may cause rapid deterioration of an already compromised patient. Patient specifically acknowledges that the 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 the 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. Risks/Side Effects of Wound Debridement: Patient acknowledges that 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 the provider has explained that bleeding after debridement may cause rapid deterioration of an already compromised patient. Patient specifically acknowledges that the 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 the provider has explained that debridement will make the wound larger due to the removal of necrotic (dead) tissue from the margins of the wound.

    a. CTPs definition: CTPs are classified into the following types:
        i. Human skin allografts derived from donated human skin
        ii. Allogeneic matrices derived from human tissue (fibroblasts or membrane)
        iii. Composite matrices derived from human keratinocytes, fibroblasts and xenogeneic collagen
        iv. Acellular matrices derived from xenogeneic collagen or tissue

    b. Donor Screening: The donated CTP's have been determined to be eligible for transplantation by a Licensed Physician who is retained by the tissue bank to make such determinations. Review of donor records includes analysis of the donor medical history, performance of a risk behavior assessment, review medical records and recent physical examinations. This review allows the tissue bank to determine whether the donor is free from risk factors or whether there is clinical evidence of infection due to relevant communicable diseases and other exclusionary disease conditions. Where such potential for infection due to communicable diseases exists, the tissue is rejected. All labs performing the tests are registered with the Food and Drug Administration (FDA) and certified to perform testing on human specimens under the Clinical Laboratory Improvement Amendments (CLIA) Act of 1988 and 42 CFR part 493. An allograft of donated human tissue is deemed qualified for transplantation by a tissue bank if it meets the following criteria: 1) the results from the donor pre-screening lab tests specify the donor to be free from risk factors and active infections of applicable communicable disease agents and diseases as required by the FDA, and 2) donor results from the pre-screening lab tests must be negative and/or non-reactive for the following applicable communicable disease agents determined by the following: testing for Hepatitis B and C Viruses (HCV/HBV); testing for Human Immuno-Deficiency Viruses Types I and II (HIV I/II AB); Nucleic Acid Testing (NAT) for HIV, and Hepatitis B and C; Core Antibody Testing for Hepatitis B (HBC AB); Testing for Hepatitis B Surface Antigen (HBS AG); Human T-Cell Lymphotropic Viruses I and II (HTLV I/II); and testing for Reactive Plasma Reagin (RPR) (which tests for non-specific antibodies that may indicate a syphilis infection). The tissue bank that provides allografts our office uses for this procedure has informed this office that the allografts and donor have met the above requirements. By law, the laboratories performing human specimen tests are certified and meet the requirements as determined by the Centers for Medicare and Medicaid (CMS), per CLIA and 42 CFR part 493, and the FDA. Each lab is additionally required to maintain appropriate records of the donor with allograft ID number (lot number) for purposes of tracking the allograft post treatment.

c. Additional Risks: While great measures to ensure the safety of the allograft product have been taken by the supplier, I understand that current technologies cannot preclude the transmission of certain diseases known or unknown, and that neither the supplier of the injectable nor the medical professional performing this procedure can make any claims concerning the biologic properties and safety of allograft tissues despite the tissue bank confirming it has collected, processed, screened, tested, stored, and distributed the product in compliance with all current regulations.

11. 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. The purpose of these images is to monitor the progress of wound treatment and ensure continuity of care. Patient further agrees that their referring provider or other treating 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 the WCC 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 the WCC upon written authorization from the Patient or Patient's legal representative.

12. Use and Disclosure of Protected Health Information (PHI): Patient consents to BSH, Sc dba Advanced Care Specialists' 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 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 the WCC 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 BSH, Sc dba Advanced Care Specialists, its affiliates, and business associates for purposes related to treatment, payment, and health care operations.

13. 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.

The patient hereby acknowledges that he or she has read and agrees to the contents of sections 1 through 13 of this document. Patient agrees that his or her medical condition has been explained to him or her by the provider. Patient agrees that the risks, benefits and alternatives of all care, treatment and services that Patient will undergo while a patient at the Advanced Mobile Wound Care have been discussed with Patient by provider. Patient understands the nature of his or her medical condition, the risks, alternatives and benefits of treatment, and the consequences of failure to seek or delay treatment for any conditions. Patient has read this document or had it read to him/her and understands the contents herein. The Patient has had the opportunity to ask questions of the provider and has received answers to all of his or her questions.

By signing below, Patient: (1) consents to the care, treatment, and services described in this document and orally by the provider, (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 provider, Hospital and Advanced Mobile Wound Care, LLC and New Life Health, LLC.

Patient Name: _____ DOB: _____

Patient signature: _____ Date: _____

Witness: _____ Date: _____

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Interpreted/Translated by (if applicable) : _____

In the event above not signed by the patient, the undersigned acknowledges that they have the legal right to sign the document.

Legal Guardian or Representative:_____ Date: _____

Printed Name: _____ Relationship: _____

The undersigned provider 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).

Provider signature: _____ Date: _____