WOUND CARE
and HYPERBARICS

PATIENT POLICIES

Welcome to **R3**! Thank you in advance for allowing us to treat your wound care / HBO needs. The following information is provided for your benefit so that we may serve you better. Please read and sign at the bottom. A copy will be provided for your records.

PAYMENTS: All applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your appointment.

HYPERBARIC THERAPY: If you are prescribed Hyperbaric Oxygen Therapy, we will submit the request to your insurance for authorization. Upon approval, you are required to pay all applicable fees, deductibles, coinsurance, or co-pays at the start of your treatment. If you are unable to provide full payment, we will designate an appropriate payment plan in order for you to complete your treatment. If you decide to stop your treatment at any time before the required prescription is completed, there will be **NO REFUNDS,** unless it is decided by a provider that it is medically necessary to stop your treatment or it is requested by your physician /surgeon.

CANCELLATIONS/NO SHOW: If you need to cancel your appointment, it is your responsibility to do so 4 hours prior. For each **NO SHOW**, R3 reserves the right to charge you a **$40.00** fee to cover administrative costs and lost treatment time. Call **(817) 337-6604**, Option 1 for Heritage Trace, Option 2 for Lewisville or Option 3 for Arlington. Call **(210) 582-5304** for Stone Oak.

APPOINTMENT TIME: R3 requests that you arrive 15 minutes before your scheduled appointment to assure completion of treatment during your allotted time. This will facilitate the ability to treat you as scheduled. In an effort to serve all patients well, your appointment may be rescheduled if you arrive 15 minutes past your scheduled time without notice.

HMO REFERRALS: If your policy requires written authorization from your Primary Care Physician (PCP), we will request authorization, in advance, for established patients. This is done as a courtesy for our patients; however, we cannot guarantee authorization will be granted. Please verify with your Primary Care Physician to ensure your visit is pre-authorized, to avoid having to make payment in full.

CHANGE OF INFORMATION: It is your responsibility to provide us with any change regarding your address, phone number or insurance information as soon as possible. Change of insurance will require the completion of a new Patient Demographics Form.

AFTER HOURS CARE: In an emergency, please contact your physician. In a life-threatening emergency, call 911.

MEDICAL RECORDS REQUEST: As per the rules adopted by the Texas State Board of Medical Examiners, our office will respond to the requests for the completion of medical forms following the receipt of the appropriate fees. FEES:As per the rules adopted by the Texas State Board of Medical Examiners, our office will charge $25.00 for the first 20 pages and $.50 for each page thereafter and the actual cost of mailing, shipping or delivery where applicable. Forms will be completed within five business days.

COLLECTION AGENCY FEES: In the event that your account is turned into collections, you will be responsible for the collection agency fees.

_____	_____	_____
Signature	Patient Name	Date

WOUND CARE and HYPERBARICS

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: ____

Date of Birth: _____ Social Security Number: _____ Gender: M F

Marital Status: Married ____ Divorced ____ Separated ____ Preferred Language (*other than English*)
Single ____ Life Partner _____ Widowed ____ _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Phone Number: _____ Alternate Phone Number: _____

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number:_____

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient: (If self, skip to Emergency Contact) Spouse: ____ Parent: _____ Other: _____

Last Name: _____ First Name: _____ DOB: _____

EMERGENCY CONTACT/AUTHORIED HIPPA RELEASE

Last Name: _____ First Name: _____ MI: ____

Phone Number: _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance: _____ Phone Number: _____

ID # _____ Group # _____

Secondary Insurance: _____ Phone Number: _____

ID # _____ Group # _____

WOUND CARE
and HYPERBARICS

MEDICAL AUTHORIZATION RELEASE FORM

Patient:

Full Legal Name: _____ Date of Birth: _____Gender: M F

Home Address: _____

Information for Medical Treatment:

Name of Practice: **R3 Wound Care & Hyperbarics**

This Authorization shall be in force on _____ and remain effect until _____, I understand that I have the right to revoke this authorization, in writing, at any time except to the extent that action has been taken in reliance thereon.

Authorization to Release Medical Information

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of **R3 Wound Care and Hyperbarics** to release or disclose any protected health information to _____, to include all or only:

○ Medical History	○ Insurance Records	○ Billing Information

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my Signature below. I am entitled to a copy of this authorization.

Patient's or Legal Guardian's Signature: _____

Relationship to Patient: _____

Witness Signature: _____ *Date:* _____

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

WOUND CARE and HYPERBARICS

MEDICAL RECORDS RELEASE FORM

Name of Patient: _____

Date of Birth: _____**Social Security Number** _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR: Continuing Medical Care

INFORMATION TO BE RELEASED OR ACCESSED:

1) History & Physical Consultation Report
2) Emergency Room Record, Discharge / Death Summary
3) Operative Reports
4) Face Sheet
5) Lab/Path Reports / Diagnostic Reports / Images
6) Other: _____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address). Please select one:

○ R3 Wound Care & Hyperbarics 4545 Heritage Trace, Ste 1500 **Fort Worth, TX 76244**	○ R3 Wound Care & Hyperbarics 18626 Hardy Oak Blvd #103 **San Antonio, TX 78258**	○ R3 Wound Care & Hyperbarics 4150 N Collins Street **Arlington, TX 76005**	○ R3 Wound Care & Hyperbarics 1720 FM 544, Suite 100 **Lewisville, TX 75056**

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnosis, and /or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire twelve (12) months from the date of my signature, unless I revoke the authorization prior to that time.

Signature: _____ **Date**: _____

WOUND CARE and HYPERBARICS

CONSENT FOR SERIAL CONSERVATIVE SHARP DEBRIDEMENTS

TO THE PATIENT: You have been told that you should consider medical treatment/surgery. The Texas Medical Disclosure Panel Law requires us to tell you (1) the nature of your condition, (2) the general nature of the medical treatment/surgery, (3) the risks of the proposed treatment/surgery, as defined by the Texas Medical Disclosure Panel, (4) reasonable therapeutic alternatives and material risks associated with such alternatives.

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedures so that you can decide whether to undergo the procedure. In keeping with the Texas Law of Informed Consent, we wish to inform you as completely as possible.

Please read this form carefully and feel free to ask questions.

Patient Name: _____

Treatment/Procedure:

To promote wound healing and decrease the risk for infection of the wound(s), the recommended procedure may include: Serial Conservative Excisional (Surgical/Selective) Wound Debridements (repeated procedures involving removal of devitalized tissue from wound(s) with a sharp instrument), Serial Conservative Non-Excisional Wound Debridements, Incision and Drainage (I&D), Ultrasonic Debridements, and/or other

_____

_____

_____

Patient Condition:

Patient's diagnosis, description of the nature of the condition or ailment for which the medical treatment or other therapy described above is indicated and recommended: (1) for an open wound or wound/incision requiring attention to aid in healing, (2) other:

_____

_____

_____

Risks of Treatment/Procedure:

The risks associated with the medical treatment or therapy described above, as required by the Texas Medical Disclosure Panel Law are: (1) Infection of the wound, (2) infection in the blood, (3) mild to profuse bleeding, (4) disfiguring scars, (5) the loss, or loss of function, of any organ or limb, (6) pain, (7) death, (8) other

_____

_____

_____

Reasonable therapeutic alternatives and the risks associated with such alternatives are: (1) Chemical Debridement – results in slower healing and increased risk of infection. (2) other

_____

_____

_____

WOUND CARE
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Patient Notice:

(1) All information given to me and, in particular, all estimates made to the likelihood of occurrence of risk, of this or alternate procedures or as to the prospects of success, are made in the best professional judgment of my clinical provider. The possibility and nature of complications cannot always be accurately anticipated and, therefore, there is and can be no guarantee, either expressed or implied, as to the success or other results of the medical treatment or surgical procedure.

(2) Nothing has been said to me, no information has been given to me, and I have not relied upon any information that is inconsistent with the information set forth in this document.

(3) I have had the opportunity to disclose to and discuss with the clinical provider all information, risks, or other potential consequences of the medical treatment or surgical procedure that are of particular concern to me. I have had an opportunity to ask, and have asked, any question concerning the information in this document and any proposed treatment. My questions have been answered in a satisfactory manner.

(4) In the event of an occupational exposure, blood or body fluid contact, I agree to follow R3 policy and procedures, including but not limited to lab work and follow up.

Consent: ***I hereby authorize and direct the designated authorized clinical provider to administer or perform the medical treatment or surgical procedure described in this document, including any additional procedures or services as they may deem necessary or reasonable, including the administration of a regional anesthetic agent, x-ray or other radiological services, laboratory services, and the disposal of any tissue removed during a diagnostic or surgical procedure. And I hereby consent thereto.***

I have read and understood all information set forth in this document, including any attachment, and all blanks were filled in prior to my signing. This authorization for and consent to medical treatment or surgical procedure is and shall remain valid until revoked.

I acknowledge that I have had the opportunity to ask any questions about the proposed medical procedure or surgical procedure described in the document, including risks and alternatives, and acknowledge that my questions have been answered to my satisfaction.

Patient/Authorized Designee _____

Date _____

If consent is signed by someone other than the patient, state the reason why:

_____

_____

Clinical Provider:

I hereby certify that I have provided and explained the information set forth herein, including any attachments, and answered all questions of the patient, or the patient's representative, concerning the medical treatment or surgical procedure, to the best of my knowledge and ability.

Clinical Provider_____

Date _____

WOUND CARE and HYPERBARICS

PHOTO/VIDEO-AUDIO CONSENT

I hereby consent to allow R3 Wound Care and Hyperbarics, its agents, representatives, employees, successors, or assign to photograph, and or videotape. I further grant to R3 Wound Care and Hyperbarics the right and permission to copy-right, reproduce, broadcast, telecast and/or publish the photograph(s), film, videotape, recordings, endorsement or copy in which I may be included in whole or part, or composite form for utilization in diagnostics, documentation, treatment and/or teaching or demonstration purposes, or art purposes, trade, web site use, advertising and all advertising media, or for any lawful reproduction purpose; I further agree to release R3 Wound Care and Hyperbarics, its agents, representatives, employees, successors, or assigns from any liability by virtue of any blurring, distortion, or use in composite form, that may occur or be produced in the taking and reproducing of said photograph(s), videotape, or recording, or in any processing tending toward the completion of the finished product. I understand that these images will be stored in a secure manner to protect them from unintended use by unauthorized parties.

I understand and agree these images or recordings may include or infer information regarding medical conditions and/or treatment at the R3 Wound Care and Hyperbarics locations and affiliated entities.

○ Agree ○ Disagree

I understand and agree that I have the right to rescind this agreement and R3 Wound Care and Hyperbarics will not make any additional media placements using my images or recordings. I also understand that R3 Wound Care and Hyperbarics will not withdraw any media where my images or recordings have already been placed. To rescind approval; I must submit a request in writing to R3 Wound Care and Hyperbarics.

Please list any restrictions:

_____

_____

_____

Date: _____/____/____ Signature: _____

Print Name: _____

Guardian (if above person is under 18 years of age or unable to sign)

Date: ____/____/____ Signature: _____

Print Name: _____

Address: _____

City: _____ State: _____ Zip Codes: _____

WOUND CARE and HYPERBARICS

ASSIGNMENT OF BENEFITS

Private Insurance Authorization for Assignment of Benefits and Information Release

I, the undersigned, authorize payment of medical benefits to R3 Wound Care and Hyperbarics for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my insurance policy. I also authorize R3 Wound Care and Hyperbarics to release to my insurance company, referring physician and other consultants on my case information concerning health care advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Date: _____ Signature: _____

Certification

R3 Wound Care and Hyperbarics is pleased to offer you treatment. However, you are advised that according to most commercial insurance policies and generally accepted practice, treatment for work related chronic injuries must first be filed under Texas Workman's Compensation.

*I, _____, hereby certify that I **am/am not** seeking treatment for an illness or injury that resulted from an incident/accident at my place of work or from a motor vehicle accident.*

MVA/Date of Incident: _____

Print Patient Name: _____ Date: _____

Patient Signature: _____

Health Insurance Portability and Accountability Act

By signing this document, I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices of R3 Wound Care and Hyperbarics.

Signature:_____ Date: _____

Printed Name: _____

WOUND CARE and HYPERBARICS

MEDICAL TREATMENT AUTHORIZATION FORM

Minor

Full Legal Name: _____ Date of Birth: _____Gender: M F

Home Address: _____

Information for Medical Treatment

Location of Practice (please select one):

○ R3 Wound Care & Hyperbarics 4545 Heritage Trace, Ste 1500 **Fort Worth, TX 76244**	○ R3 Wound Care & Hyperbarics 18626 Hardy Oak Blvd #103 **San Antonio, TX 78258**	○ R3 Wound Care & Hyperbarics 4150 N Collins Street **Arlington, TX 76005**	○ R3 Wound Care & Hyperbarics 1720 FM 544, Suite 100 **Lewisville, TX 75056**

Note any other significant medical information: _____

_____

_____

Authorization and Consent of Parent(s) or Legal Guardian(s)

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of R3 Wound Care and Hyperbarics to treat the above stated minor without the supervision of a parent/legal guardian.

_____**TRANSPORTATION PERMISSION**: The undersigned does also hereby give permission for the above stated minor to ride in any vehicle driven by an approved and licensed ADULT while being treated at the R3 Wound care and Hyperbarics facility. My child/minor and I understand that SEAT BELTS MUST BE WORN AT ALL TIMES during transportation.

**Please initial if your child/minor requires transportation*

This authorization is effective through: _____

Date: _____

Parent/Legal Guardian Signature: _____

Printed Name: _____

Witness Signature: _____

Printed Name: _____

WOUND CARE and HYPERBARICS

Vital Signs

BP: _____

HR: _____

Temp: _____

R: _____

MEDICAL HISTORY FORM

Patient Name: _____ Date: _____

Are you presently working? Yes _____ No _____ Date of next physician's visit: _____

Do you have, or have you had, any of the following?

	Yes	No	Family			Yes	No
Diabetes					Allergies to Medications		
Chest Pain					Allergies to Environment		
High Blood Pressure					Other Allergies		
Heart Disease							
Heart Attack					Taking Blood Thinners?		
Stroke/CVA					Hernia		
Heart Palpitations					Are you pregnant?		
Pacemaker					Metal Implants		
Headaches					Dizziness/Fainting		
Kidney Problems					Recent Fracture		
Seizures					Surgeries (List below)		
Cancer					Skin Abnormalities		
Osteoporosis					Sexual Dysfunction		
Bowel/Bladder Abnormalities					Nausea/Vomiting		
Urine Leakage					Sinus Problems		
Blood Virus (HIV/AIDS/Hep C)					Ringing in your ears		
Asthma/Breathing Difficulties					Rheumatoid Arthritis		
Liver/Gallbladder Problems					Special Diet Guidelines		
Optic Neuritis/Eye Disorders					Hypoglycemia (Low sugar)		
COPD/Emphysema/Lung Issues					Smoking		
Blood Clotting Disorder/DVT					Recent cardiologist work up?		
Lymphedema					Other		

If you answered yes to any of the above, please briefly explain and give approximate dates: _____

_____

_____

_____

_____

WOUND CARE and HYPERBARICS

Is there any other information regarding your past medical history that we should know about? _____

_____

_____

_____

List any current medications and dosage. _____

_____

_____

_____

_____

Patient agrees for medication retrieval inquiry: Yes _____ No _____

What is your preferred pharmacy?

Name: _____

Address: _____

Phone: _____ Fax number: _____

Do you use tobacco? Yes _____ No _____ If yes, what form? _____

Do you have a Do Not Resuscitate (DNR) order in place? Yes _____ No _____

Patient's Signature _____ **Date**: _____

Signature of Guardian: _____ **Date**: _____

(if patient is a minor)