INOVA HEALTH SYSTEM

Wound Healing Center

Patient Registration

PATIENT INFORMATION

Name: _____ Home phone: _____
Last Name First Name Middle Initial

Street Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Birthdate: _____ Age: _____

Sex: Male___ Female___ Marital Status: Single___ Married___ Widowed___ Separated___ Divorced___

Employer: _____

Employer Address: _____

Work Phone: _____ Are You Currently Working: yes____ No_____

Email Address: _____

EMERGENCY CONTACT INFORMTION

Emergency Contact Name: _____

Phone: Home: _____ Work: _____ Cell: _____

Relationship To Patient: _____

PATIENTS WITHOUT MEDICAL INSURANCE

I, the undersigned, certify that I am responsible for all charges incurred for medical services rendered to me or my dependants by the physicians of INOVA Wound Healing Center. I understand that payment in full is required at each appointment. I further agree in the event of non-payment, to bear the cost of collection, and/or court cost and reasonable legal fess should this be required.

My preferred method of payment is: Cash_____ Personal check _____ Credit Card_____

_____ _____
Signature of Patient or Responsible Party Date

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have the insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I further agree in the event of non-payment, to bear the cost of collection and/or court cost and reasonable legal fess should this be required.

_____ _____
Signature of Insured or Responsible Party Date

INOVA HEALTH SYSTEM

Wound Healing Center
2501 Parker's Lane
Alexandria, VA 22306
PH: 703-664-8020
Fax: 703-664-7317

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Patient Label:

I authorize ***Inova Wound Healing Center*** to release healthcare information of the patient named above to:

Name: _____

Relationship: _____

Phone: _____

Name: _____

Relationship: _____

Phone: _____

This authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date Signed: _____

Witness Signature: _____ Date Signed: _____

INOVA™

1ADA

Inova Staff: At the first opportunity, please complete this form with the patient or companion and have it scanned into the patient's electronic medical record. **Complete one form per person requesting accommodation.**

Patient or Companion: If you or any companion assisting in your care has a special need, please indicate below:

☐ Patient's medical condition does not allow completion at this time.

	Patient	Companion/Legal Guardian
Are you deaf or do you have serious difficulty hearing?	☐ Yes ☐ No	☐ Yes ☐ No
Are you blind or do you have serious difficulty seeing, even when wearing glasses?	☐ Yes ☐ No	☐ Yes ☐ No
Do you have serious difficulty walking or climbing stairs? (5 years old or older)	☐ Yes ☐ No	☐ Yes ☐ No
Do you have any other special needs or disability that require services or accommodations during your visit today?	☐ Yes ☐ No	☐ Yes ☐ No
If you have indicated a need above, do you or your companion need services or accommodations related to your identified need(s)?	☐ Yes ☐ No	☐ Yes ☐ No

Please describe type of accommodation requested:

_____

_____

Do you have any special instructions for care providers? If so, please describe below:

_____

_____

Staff Notes regarding accommodations given: (**Inova Staff:** Please document in detail accommodation(s) requested and services given.)

_____

_____

By my signature below, I hereby certify that: (i) I have been given the opportunity to communicate whether I and/or my companion has a disability or special need requiring accommodation; (ii) I have had the opportunity to communicate my needs to staff as reflected above and that the above selections are true, accurate and complete; (iii) I understand that Inova Health System will use its best efforts to accommodate my requests and that any accommodations provided will be given free of charge; (iv) I have been offered/given a copy of the Patient Rights brochure which contains information for filing a complaint if I am unsatisfied with my requested accommodations during my visit today.

_____ _____

Signature of Patient/Patient Representative/Companion Date Time

Print: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Family Member ☐ Friend ☐ Other _____

_____ _____

Signature of Employee Witness Date Time

Print: _____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name _____

DOB: _____ MR# _____

Inova Ambulatory Services

Americans with Disabilities Act (ADA)/ Special Needs Assessment

CAT # 20328DT-1P / R052714 • PKGS OF 100

Inova Mt. Vernon Wound Healing Center
New Patient Intake Form

Place patient label here

Primary Care Provider:_____

Referring Provider: _____

Home Health Agency (if applicable):_____

Pharmacy name and phone number:_____

(please circle appropriate responses below)

PAIN: No Yes Location: _____ Pain level (scale 1-10): _____

Describe pain (i.e. sharp, dull, aching, stabbing): _____

Frequency of pain: Constant Intermittent Occasional

How are you managing your pain? _____

NUTRITION:

Height: _____ Weight: _____

Diet: Regular Cardiac Diabetic Low Sodium Other_____

Recent weight change: None Loss Gain **Recent change in appetite:** None Loss Gain

Do you take nutritional supplements and/or supplement shakes?_____

Do you have any difficulties preventing eating? (If yes, describe)_____

Do you have any cultural, ethnic, or religious restrictions in your diet?_____

SOCIAL HISTORY:

Employment Status: Employed Unemployed Retired Disabled

Occupation:_____

Marital Status: Single Married Widowed Divorced

Living Conditions: Alone With others Assisted Living Nursing Home

Other:_____

Smoking Status: Never Smoker Current Smoker Former Smoker

Year Started: _____ Year Quit: _____ Packs per day: _____

Alcohol intake: Number of drinks: _____ / Day Week Month

Do any medical conditions run in your family (i.e. cancer, diabetes, heart disease, hypertension)?

_____

SURGICAL HISTORY (please indicate year):

_____

_____

_____

_____

ALLERGIES:

_____

_____

_____

MEDICATIONS:

Please include prescription, over-the-counter and vitamins. Alternatively, provide a separate list.

Medication	Dose	Frequency

MEDICAL HISTORY (please circle all that apply):

GENERAL:
Chills
Fever
Weakness

SKIN:
Itching
Rash
Dermatitis
Acne
Dryness
History of ulcers
Pigment changes
Keloid
Suspicious mole(s)

IMMUNOLOGY:
HIV/AIDS
Lupus
Scleroderma
Pyoderma gangrenosum
Rheumatoid arthritis
Collagen vascular disease

EYES:
Cataracts
Blurred vision
Blind/visually impaired
Retinopathy
Retinal detachment
Glaucoma
Macular Degeneration

ENT:
Hearing Loss
Middle ear implant
Meniere's disease
Difficulty swallowing
Dentures
Recent upper respiratory Infection
Sinus surgery
Eustacian tube dysfunction

RESPIRATORY:
COPD
Bronchitis
Emphysema
Asthma
Shortness of breath
Chronic cough
Allergies
Pulmonary fibrosis
Wheezing
Blood tinged sputum
Tuberculosis
Oxygen dependency
Apnea
Snoring

CARDIOVASCULAR:
Angina
Heart attack
CABG
Angioplasty
Arrhythmia (a-fib)
Palpitations
Pacemaker
Coronary artery disease
Heart failure (CHF)
Orthopnea
Shortness of Breath on exertion
High blood pressure
Heart murmur

PERIPHERAL VASCULAR:
Deep vein thrombosis
Claudication
Leg swelling
Bypass
Angioplasty
Vein surgery
Night pain (in the legs)
Rest pain (in the legs)

GASTROINTESTINAL:
Nausea/Vomiting
Diarrhea
Bowel Incontinence
Liver disease
Hepatitis: A, B, or C
Ascites
Cirrhosis
Jaundice
Malnutrition
Dysphagia
Blood in stool
Black stool
GI ulcers

GENITOURINARY:
Urinary tract infections
Dysuria
Nocturia
Frequency
Catheter
Urinary Incontinence
Dialysis
Kidney failure
Kidney transplant

MUSCULOSKELETAL:
Painful nails
Charcot foot
Osteoarthritis
Joint stiffness
Joint swelling
Amputation
Muscle wasting
Myalgia
Fractures (please specify):

_____

NEUROLOGICAL:
Neuropathy
Dizziness
Stroke
TIA
Seizures
Migraines
Degenerative nerve disease
Paraplegia
Quadraplegia
Spinal cord injury
Syncope

ENDOCRINE:
Diabetes (type ____)
Hypothyroid
Hyperthyroid
Addison's Disease

HEMATOLOGIC & LYMPHATIC:
Anemia
Bleeding disorder
Sickle cell
Hypercoagulable
Bruises easily
Lymphedema

PSYCHOLOGICAL:
Depression
Anxiety
Bipolar Disorder
Claustrophobia
PTSD
Impaired judgement
Short term memory loss
Alzheimer's or dementia
Psychosis

OTHER:

_____

_____

I certify that I have been made aware of Inova Health System's **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Inova Health System's health care operations. The Notice also describes my rights and Inova Health System's duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Inova Health System's web site at www.inova.org. I may request that a copy be mailed to me by calling **703-204-3342.**

Inova Health System reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**. I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing Inova Health System's web site listed above to view the most current version.

_____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

_____

NAME OF PATIENT OR PERSONAL REPRESENTATIVE

_____

DATE

_____

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

PATIENT IDENTIFICATION

INOVA HEALTH SYSTEM

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

CAT #84498 / R020609
PKGS OF 100

MR 32-06

1PMTREV

Patient Name: _____ Medical Record #: _____

Date of Service: _____ Location: _____ Account #: _____

1. **Physicians Who Are Not Employees or Agents of Hospital – I understand that most of the physicians and surgeons furnishing services to me, either individually or through professional corporations including, but not limited to emergency department physicians, radiologists, anesthesiologists, neonatologists, physiatrists, pathologists, and others are independent contractors and are not employees or agents of Inova Health System or this Hospital.** I understand that they are independent in the exercise of decisions requiring professional medical judgement, including decisions about my care. **I understand that I may receive separate bills for such independent contractor services.**

2. **Assignment and Coordination of Insurance Benefits** – I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits to which I/the patient may be entitled. I hereby assign payment(s), if any, from my insurance carrier(s)/health benefit plan(s) to Inova Health System (or its affiliate) and each of the independent contractor physicians and/or professional corporations for services rendered to me. The direct payment hereby assigned and authorized includes any hospital and/or medical insurance benefits to which I am otherwise entitled, including any Major Medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to the Inova Health System (or its affiliate), the independent contractor physicians and/or professional corporations for services rendered to me during the applicable periods of medical care.

3. **Unauthorized, Non-Covered, or Out of Plan Services** – I understand that if my insurance company or health maintenance organization does not consider this admission or any service rendered during this admission a covered service or has not authorized this service, they will not pay for this admission or the service rendered during this admission or outpatient visit. I agree to be fully responsible for payment to the Hospital and any independent contractors providing services to me/the patient for this admission or any service if determined by my insurance company or health maintenance organization to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance or other charge. I also understand that certain physicians and surgeons, such as radiologists, anesthesiologists, neonatologist, physiatrists, pathologists and others may not be participating physician members of my managed care health plan. In the event that my managed health care plan does not reimburse these services provided to me, I acknowledge that I will be responsible for any balance that it declines to pay for such services. ☐

4. **Authorization to Release Information and Process Claims** – I authorize release of information, including financial information and confidential health information and medical records regarding services rendered during this episode of care or any related services, which may include records relating to treatment for substance abuse, to my insurance carrier(s), managed care plan or other payor, including past and/or present employer(s), Medicare, Medicaid, or Tricare, authorized private review entities, and/or utilization review entities acting on their behalf, authorized chart reviewers and market surveyors of the Hospital, the billing agents and collection agents or attorneys of Inova Health System (or its affiliates) and/or independent contractor physicians and/or professional corporations, my employer's Workers' Compensation carrier, and, as applicable, the Social Security Administration, the Centers for Medicare & Medicaid Services, the Peer Review Organization acting on the behalf of the federal government, and/or any other federal or state agency for the purpose(s) of satisfying billed charges and/or facilitating utilization review and/or conducting chart review and market surveys and/or otherwise complying with the obligations of state or federal law. A photocopy of this authorization may be honored.

5. **Non Responsibility for Personal Property** – I understand and agree that the Hospital and Inova Health System (or its affiliates) cannot be responsible or liable for any theft of, loss of, or damage to any personal property or other possessions which are not placed in the Hospital's vault for safekeeping. I further understand and agree and authorize that any such money and/or belongings not claimed within sixty (60) days of my discharge from the Hospital may be destroyed or disposed of at the Hospital's discretion, and that any interest or right I may have had in such money or other valuables shall cease. ☐

6. **For Medicare Recipients Only** – I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to the Hospital and/or independent contractors for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment. My signature below acknowledges receipt of "An Important Message from Medicare" on the date listed below.

7. **Patient Rights and Advance Directives** – Hospital patients have specific rights and a list is provided in the Patient Information Handbook and brochure that are provided to you by the Hospital. Federal and State laws also give you the right to complete a living will or select a durable power of attorney for health care. The Hospital's policy on Advance Directives and a brochure on Advance Directives will be made available to you upon request.

8. **Responsibility for Payment** – In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered services. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorneys' fees and other collection costs.

9. Residents, interns, medical students and other health care professional students may participate, under the supervision of an attending physician or other health care professional, in patient care as part of the Hospital's education programs.

By signing below, I certify that I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms. I further certify that I am the patient listed above or am the guardian, duly authorized representative, parent or other family member of the patient.

_____ _____

PATIENT (GUARDIAN, ETC.) DATE

_____

RELATIONSHIP TO PATIENT (IF NOT SIGNED BY PATIENT)

_____ _____

WITNESS DATE

PATIENT IDENTIFICATION

INOVA HEALTH SYSTEM

AUTHORIZATION FOR CLAIMS, PAYMENT, AND REVIEWS

White: Medical Records • *Yellow:* Patient Copy

CAT #96275 / R040409 • PKGS OF 100