PATIENT REGISTRATION 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.

PATIENT INFORMATION

Last Name:_____ First Name:_____ MI: _____

Date of Birth:_____ Gender: M F Preferred Language (*other than English*)____

Marital Status: Married _____ Divorced_____ Separated _____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 HIPAA RELEASE

Last Name:_____First Name:_____MI: _____

Phone Number:_____Relationship: _____

PREFERRED PHARMACY

What is your preferred pharmacy?

Name:_____

Address:

Phone:_____ Fax number: _____

Vital Signs

Height: _____Weight: _____ BP: _____ HR: _____ Temp: _____ R: _____

MEDICAL HISTORY FORM

Patient Name:_____ Date: _____

Are you presently working? Yes _____ No _____ Primary Care Physician: _____

Specialists: _____

_____

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

	Yes	No	Family
Diabetes			
If diabetic, recent A1C: Type 1 or Type 2?			
High Blood Pressure			
Heart Disease			
Heart Attack			
Taking Blood Thinners			
Stroke/CVA			
Congestive Heart Failure			
Pacemaker / Defibrillator			
Headaches			
Kidney Problems / Dialysis			
Seizures			
Cancer			
If yes, what type?			
Anemia			
Urine Leakage			
Gallbladder Problems			

	Yes	No
Liver Problems		
Cataracts		
COPD/Emphysema/Lung Issues		
Blood Clotting Disorder/DVT		
Lymphedema		
Pregnant		
Metal Implants		
Recent Fracture		
Blood Virus (HIV/AIDS/Hep C)		
Asthma/Breathing Difficulties		
Sinus Problems/Seasonal Allergies		
Peripheral Vascular Disease		
Recent vascular workup?		
Smoking		
If yes, how much? When did you stop?		
Recent cardiologist work up?		
Other		

If you answered yes to any of the above, please briefly explain and give approximate dates. Please be sure to list any / all surgeries:

_____

_____

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

_____

List any current medications and dosage: _____

_____

_____

_____

List any known allergies to medications: _____

Do you have a Home Health Agency (HHA)? If yes please provide name and phone number:

_____

Do you have a Do Not Resuscitate (DNR) order in place? Yes_____No _____

CONSENT FOR CARE & FINANCIAL RESPONSIBILITY

_____ (Initials) Consent for Treatment & Use of Records I, the undersigned, voluntarily consent to treatment by the practitioners and clinical staff of R3. I have been offered the Notice of Privacy Practices (NPP), which contains additional information about the use of my PHI.

_____ (Initials) Acknowledgement of Financial Responsibility: I accept that I am financially responsible for all services rendered on my behalf for which a charge may be associated. I accept personal responsibility for all co-payments, deductibles, and non-covered services, as dictated by my insurance coverage, plus any collection costs for amounts personally owed by me. In the event that this visit is based on a Worker's Compensation claim and my Worker's Compensation claim is not accepted, I agree to have the fees associated with services sent to my private health insurance company. I acknowledge that not all services provided by R3 are covered by my insurance plan for one or more reasons, including but not limited to exclusions from my insurance plan, my insurance plan's designation of R3 as an out-of network provider, and/or my failure to provide my insurance card.

_____ (Initials) Medical Record Requests: In accordance with applicable law, 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 50 pages and $50 for 51 or more pages. Forms will be completed within five business days after receipt of payment.

_____ (Initials) Appointment Cancelations/No Shows: R3 requests that you arrive 15 minutes before your scheduled appointment to assure completion of treatment during your allotted time. In an effort to serve all patients well, your appointment may be rescheduled if you arrive 15 minutes past your scheduled time without notice. If you need to cancel your appointment, it is your responsibility to do so 24 hoursprior to your appointment. For each **NO SHOW**, R3 reserves the right to charge you a **$40.00** fee to cover administrative costs and lost treatment time.

I understand the obligations outlined above and I authorize payment directly to R3 for services for which R3 accepts payment. I accept responsibility for all charges if I do not have medical insurance. I have been informed that the services provided may not be covered by my insurance plan.

_____ _____

Signature of Patient or Guardian if Patient is a Minor **Date**

PRIVACY CONSENTS & AUTHORIZATIONS

Receipt of Notice of Privacy Practices: I acknowledge that I have received a copy of the Notice of Privacy Practices (the "Notice") for R3 Wound Care and Hyperbarics.

_____ _____

Signature of Patient or Guardian if Patient is a Minor **Date**

Consent to Communications: I may be contacted via email, phone and/or text messaging, according to the information provided in my patient registration information, to remind me of an appointment, to obtain feedback on my experience with our healthcare team, and to provide general health reminders/information such as appointment reminders. By signing below, I consent to receiving appointment reminders and other healthcare communications/information from R3 at that email, mailing address or phone number I provided. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. I understand that texting has benefits: it can be quicker and more convenient than other forms of communication. I also understand that texting is not as secure as other forms of communication, and that the information may not stay private if it is included in text messages. I can revoke my consent at any time by contacting R3. My revocation of consent will not affect my ability to obtain future healthcare nor will it cause the loss of any benefits to which I am entitled.

_____ _____

Signature of Patient or Guardian if Patient is a Minor **Date**

Authorization to Use or Disclose Health Information for Marketing Purposes:R3 Wound Care and Hyperbarics ("R3") is always pleased when patients are willing to communicate the stories, experiences, and information about their treatment received at R3. Sharing your story can help others who are interested in knowing more about the patient services provided by R3 health care providers and can help R3 promote its mission of service. R3 respects the privacy of our patients, visitors, and staff. Ensuring that medical information is kept confidential is among our highest priorities. R3 seeks your permission to use your medical information and your consent to allow us to take and use audio/video/photographic material of you in R3' internal and external communications, including medical and general interest publications and medical and patient education information, and distribute such materials online, in print, and in news media (such as TV, radio, newspapers, and magazines). To ensure that R3 is acting in accordance with your wishes, and using your personal information with your authorization, we ask you to fill out and sign this form. R3 will keep a copy of your written permission on file.

_____I do give my permission for R3 to use my or my child's name and share details of my or his/her treatment and experience as a patient in communications produced by or on behalf of R3, and consent to take and make use of my and/or my child's audio/ video/photographic images in publications produced by or on behalf of R3. This permission extends both to electronic versions on the R3 websites and other internet/electronic applications as well as to printed, filmed, and taped versions.

_____I do give my permission for R3 to release my or my child's name and details of his/her medical care to the news and electronic media including, but not limited to, internet/online publications, TV, radio, newspapers and/or magazines, and allow the news media to make images (digital, video, or otherwise) of me or my child for purposes of illustrating my treatment and experience as a patient of R3.

I understand that I am not required to sign this authorization. R3 does not condition treatment, payment, benefit eligibility, or enrollment activities on the signing of this form. I can request a copy of this authorization be mailed to me. I understand that I will not be entitled to any payment or other form of remuneration as a result of any use of any information and audio/video/photographic material. If I decide to sign this form, I have the right to request that audio/video recording, filming, or photographing cease at any time. I am aware that my protected health information will exist forever in either a recorded, printed, and/or electronic version or other version as may develop over time and that once it is published or disclosed in any form it will continue to be used. I understand that the Facility may receive compensation related to the use or disclosure of the requested information. I understand that information about me or my child used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations at protecting privacy of an individual's

health information under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and other applicable federal and state law.

I understand that I may revoke or withdraw this permission at any time to prohibit future use of my information. To do so, I must send written notice to the R3 Privacy Officer at 9151 Boulevard 26, Suite 150B North Richland Hills, TX 76180 or by emailing Privacy@r3healing.com. I understand that R3, as well as other persons or entities, will retain copies of any such electronic or printed versions and shall retain these versions forever and that any revocation of this authorization will only extend to the versions of the information within R3’ control that have not been previously published. If not revoked/withdrawn by me, this authorization expires ten (10) years from the date that I sign it.

_____ _____

Signature of Patient or Guardian if Patient is a Minor **Date**

MEDICAL RECORDS RELEASE FORM

Name of Patient: _____

Date of Birth:_____

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 R3 Wound Care and Hyperbarics.

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 of Patient or Guardian if Patient is a Minor **Date**

R3 Wound Care and Hyperbarics Notice of Privacy Practices (NPP)

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory

Your Choices continued…

- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within the timeframes required by state and federal law. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at 682-6832300 ext 1000 or emailing Privacy@r3healing.com.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your

information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.
- Example: A doctor treating you for a wound asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.
- Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice and How to Contact Us

- The Effective Date of this Notice is 2/20/2023
- You can contact our Privacy Office at any time by calling 682-683-2300 ext 1000 or emailing Privacy@r3healing.com.

TO BE COMPLETED IN THE OFFICE

R3 Consent for Procedures

1. I _____ consent _____to perform the following:
last name, first name Provider Name

☐ Debridement- staged ☐Nail Excision ☐ Incision and Drainage ☐ Casting
☐G-Tube Replacement ☐Compression ☐Skin/Wound Biopsy ☐Other _____

Location of Procedure: _____

2. Procedure in Patient's / Authorized Person's (Power of Attorney) own words.
_____

3. I consent to the performance of procedures in addition to or different from those now contemplated but are necessary or advisable in the course of the operation due to unforeseen circumstances or Emergencies.

4. **ASSISTANTS:** I understand the procedure may be performed with the assistance of other practitioners (MA, LVN, nurse, students, NP, PT, NP, specialty vendor, etc).

5. Debridements may be performed periodically (usually weekly) on the wound described above without need for further consent.

6. **Photographs:** I consent to use of photographs of the procedure that may be used for documentation or teaching purposes.

7. I consent to disposal of tissue and or blood products as a result of the procedure.

8. **General Risks:** understand there is a risk of bleeding, infection, pain, loss of body function, paralysis, allergic reaction or even death. Although any of these risks are rare, the provider will use techniques that are standard within the industry to minimize any risks. The advantage of the procedure have been explained and the disadvantage of not performing the procedure.

9. **Specific Risks** (if applicable): _____

10. Alternative procedures have been explained (if applicable) and their possible risks and benefits.

11. I have been offered the opportunity of a second opinion.

12. **No Guarantees**: I understand there are risks involved in any procedure or treatment, and it is not possible to guarantee or give assurance of a successful result.

The procedure has been thoroughly explained to me and I have had all the opportunities to have my questions answered. I consent to the procedure above:

_____ _____
Signature of Patient/Power of Attorney (POA) Date

☐If Patient/ POA cannot complete form- verbal consent obtained in person or by phone
Telephone Number: _____ Relationship to Patient: _____ **Response to Consent**: _____
Signature of person placing call _____ Witness: _____ Date: _____

☐POA Documentation on File (if applicable) ☐Interpreter used (if applicable)

☐ ***Patient/POA explained that debridement is a staged procedure and may be performed during each exam***

_____ _____
Provider Signature Date