ADVANCED
WOUND OSTOMY & CONTINENCE CARE

Original Date:
05/01/2021
Dates Revised:
05/25/2023

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	Height: ft in Weight: lbs
Referring doctor:	**Primary Care Doctor:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:					
	Any discomfort with intercourse?				☐ Yes	☐ No

	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	Would you like information on the preparation of these?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	Age	Significant Health Problems		Age	Significant Health Problems
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

Patient Signature:_____ Date:_____

ADVANCED
WOUND OSTOMY & CONTINENCE CARE

INFORMED CONSENT FOR WOUND CARE TREATMENT

Patient Name:_____ Date of Birth:_____

Patient hereby voluntarily consents to Wound Care Treatment by any Nurse Practitioner/Physician Assistant at Advanced Wound Ostomy & Continence Care, LLC and their respective staff. Patient understands that this consent form will be valid and remain in effect as long as the patient remains active and receives services and treatments by Advanced Wound Ostomy & Continence Care, LLC. A new consent form will be obtained when a patient is discharged and returns for services and treatments. Patient has the right to give or refuse consent to any proposed service or treatment.

1. **General Description of Wound Care Treatment:** Patient acknowledges that rendering provider has explained their treatment for wound care, which can include, but not limited to: debridement, dressing changes, biopsies, skin grafts, off-loading devices, physical examinations and treatment, diagnostic procedures, laboratory work (such as wound care cultures), request x-rays, recommend hyperbaric oxygen therapy, other imaging studies and administration of medications prescribed by a medical provider. Patient acknowledges that the medical provider has given them the opportunity to ask any questions related to the services or treatments being provided and that the medical provider has answered all questions.
2. **Benefits of Wound Care Treatment:** Patient acknowledges that physician has explained the benefits of wound care treatment, which include enhanced wound healing and reduced risks of amputation and infection.
3. **Risks of Side Effects of Wound Care Treatment**: Patient acknowledges that medical provider has explained that wound care treatment can cause side effects and risks including, but not limited to infections, pain and inflammation, bleeding, allergic reaction to topical and injected local anesthetics or skin prep solutions, removal of healthy tissue, delayed healing, or failure to heal, possible scarring and possible damage to blood vessels, ,surrounding tissues, organs, and nerves.
4. **Likelihood of achieving goals:** Patient acknowledges that the medical provider has explained by following the proposed treatment plan they are more likely to have optimized treatment outcomes; however, any service or treatment can carry the risk of unsuccessful results, complications, and injuries, from both known and unforeseen causes.
5. **General Description of Wound Debridement:** Patient acknowledges that the medical provider has explained that wound debridement means the removal of unhealthy tissue from a wound to promote healing, during treatment, multiple wound debridement may be necessary.
6. **Risk/Side Effects of Wound Debridement:** Patient acknowledges the medical provider has explained the risks and/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 an injected local anesthetics or skin prep solutions, excessive bleeding, removal of healthy tissue, infections, ongoing pain and inflammation, and failure to heal. Patient specifically acknowledges that the medical provider has explained that bleeding after debridement may cause rapid deterioration of an already compromised patient. Patient specifically acknowledges that the medical 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 medical provider has explained that debridement will make the wound larger due to removal of necrotic (dead) tissue from the margins of the wound.

7. **Patient Identification and Wound Images:** Patient understands and consents that images (digital, file, etc.) may be taken by Advanced Wound Ostomy & Continence Care, LLC of the patient and all patients 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 physician or other treating physicians may receive communication, including these images, regarding the patient's treatment plan 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 Advanced Wound Ostomy & Continence Care, LLC will retain ownership rights to these images, but 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 they will be kept for the time required by law. 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 Advanced Wound Ostomy & Continence Care, LLC, upon written authorization from the patient or patient's legal representative.
8. **Use and Disclosure of Protected Health Information (PHI):** Patient consents to Advanced Wound Ostomy & Continence Care, LLC 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 Advanced Wound Ostomy & Continence Care, LLC wound database for purposes of education, research, quality assessment and improvement of proprietary clinical processes and healing algorithms. Patient's PHI may be disclosed by Advanced Wound Ostomy & Continence Care, LLC to its affiliated companies, and third parties who have executed a Business Associate Agreement. Disclosure of the patient's PHI shall be in compliance with the privacy regulations of the Health Insurance Portability and Accountability Act of 1996(HIPAA). Patient specifically authorize use and disclosure of patient's PHI by Advanced Wound Ostomy & Continence Care, LLC, its affiliates, and business associates for the purposes related to treatment, payment, and health care operations. If the patient wishes to request a restriction to how his/her PHI may be used or disclosed, the patient may send a written request for restriction to Advanced Wound Ostomy & Continence Care, LLC Chief Compliance Office at PO Box 773663, Ocala, FL 34477.
9. **Financial Responsibility:** Patient understands that regardless of his/her assigned insurance benefits, the patient is responsible for any amount not covered by insurance. Patient authorizes medical information about the patient to be released to any payor and their respective agent to determine benefits of the benefits payable for related services.

The patient hereby acknowledges that he/she has read and agrees to the contents of sections 1 through 9 of this document. Patient agrees that his/her medical condition has been explained to him/her by the medical provider. Patients agrees that the risks, benefits and alternatives of care, treatment, and services that the patient will undergo while a patient of Advanced Wound Ostomy & Continence Care, LLC has been discussed with the patient by a medical provider. Patient understands the nature of his/her medical condition, the risks alternatives, read or had it read to him/her and understands the contents herein. The patient has had the opportunity to ask questions of the medical provider and has received answers to all of his/her questions.

By signing below, patient consents to the care, treatment and services described in this document and orally by the medical provider, consents to the creation of images to record his/her wounds and consents to the transfer of health information protected by HIPAA. The medical provider has explained to the patient (or his/her legal representative), the nature of the treatment, reasonable alternatives, benefits, risks, side effects, likelihood of achieving patient goals, complications and consequences which are/or may be associated with the treatment or procedure(s).

_____

Patient Signature/Authorized Representative Date

ADVANCED
WOUND OSTOMY & CONTINENCE CARE

HIPAA Notice of Privacy Practices
Advanced Wound Ostomy & Continence Care, LLC

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operations of the physician's practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet for registration where you will be asked to sign your name and indicate which provider you are seeing. We may also call you by name when the provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization:
These situations include: As Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures: Will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative actions or proceedings, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restrictions requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location: You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, I.E., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and became effective on June 4, 2014.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of Privacy Practices:

Print Name:_____

Signature:_____ Date:_____

ADVANCED
WOUND OSTOMY & CONTINENCE CARE

ASSIGNMENT OF BENEFITS FORM

Name of Insured (print):_____

Social Security Number:_____

I request that payment of authorized insurance benefits, including Medicare, If I am a Medicare beneficiary, be made on my behalf to Advanced Wound Ostomy & Continence Care, LLC for any medical services provided to me by that organization or any of its affiliated medical providers.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity, if requested. The original will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined util the insurance company received the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form, I am accepting financial responsibility as explained for all payment for products and services received.

_____

Patient Name(Printed)

_____

Relationship to Insured.

_____

Signature of Insured/Parent/ Guardian

_____

Date

ADVANCED
WOUND OSTOMY & CONTINENCE CARE

Medical Information Release Form

Name:_____ Date of Birth: _____

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- ☐ Spouse_____
- ☐ Child(ren)_____
- ☐ Other_____
- ☐ Self_____

☐ Information is not to be released to anyone.

This Release of Information will remain in affect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☐ my cell number:_____

If unable to reach me:

- ☐ you may leave a detailed message
- ☐ please leave a message asking me to return your call
- ☐ _____

The best time to reach me is (day)_____between (time)_____

Signed:_____ Date:_____

Witness:_____ Date:_____