SWCA-AZ Wound Consultation Consent

Phone: 520-497-5080 | Fax: 520-771-6870

Patient Information

Please fill out forms entirely

Name:_____DOB: _____

Phone:_____ Alt Phone: _____

SSN:_____Marital Status: _____

Physical Address: _____

Email: _____Patient Portal Access: Y / N

Emergency Contact/relationship:_____Phone: _____

Relationship to Patient:_____

Race (circle): Hispanic/Latino American Indian/Alaska Native Black/African American

Native Hawaiian/Pacific Islander White Asian Two or More Races

Decline to State Other: _____

Ethnicity (circle): Hispanic/Latino Not Hispanic/Latino/Decline to State

Reason for Consultation: _____

Location of wound/duration:_____

Previous treatment: _____

Pharmacy: _____Address: _____

Referring Physician/Company: _____Phone: _____

Home Health Agency (if applicable): _____Phone: _____

Primary Care Physician:_____Phone: _____

Appointment Reminder: _____Text _____Phone call _____Both

Surgical Wound Care
ASSOCIATES

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Social History:

___ Current or Former Tobacco use

If yes, type (circle): Smoke Vape Pipe Dip Chew Other

If yes, how often and for how long? _____

If former use, stop date: _____

____Alcohol

If yes, how many drinks per week _____

Past Medical History:

____Diabetes

If yes, most recent A1C _____ Year diagnosed_____

____Stroke

If yes, when _____

____Heart Attack

If yes, when _____

____Cancer

If yes, type and year diagnosed _____

Treatment _____

Surgical History:

____Vascular surgery (veins or arteries)

If yes, practice/surgeon and date of surgery _____

____Other surgeries: _____

_____

Allergies: _____

Employment: _____

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Insurance Information

1. Primary Insurance Company:_____

Subscriber Name: _____

Subscriber DOB:_____Subscriber SSN: _____

Relationship to Subscriber (circle one): Self Spouse Child Other: _____

Subscriber ID #:_____Subscriber Group #: _____

2. Secondary Insurance Company: _____

Subscriber Name: _____

Subscriber DOB:_____Subscriber SSN: _____

Relationship to Subscriber (circle one): Self Spouse Child Other: _____

Subscriber ID #:_____Subscriber Group #: _____

Please provide insurance card and photo identification for verification.

HIPPA Authorization

I give permission for SWCA-AZ to RELEASE any medical information to:

Name: _____

The above-mentioned person(s) will be required to provide photo ID when picking up items.

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General Consent for Care and Treatment & Consent to Bill

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).*

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing.

You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

If I do not have medical insurance, I understand that I am responsible for all charges incurred and that I will be billed for any outstanding balances in accordance with SWCA-AZ billing policy.

If my insurance is accepted, I authorize payment of benefits to SWCA-AZ or will reimburse SWCA-AZ if I am paid directly by my carrier.

I hereby authorize that SWCA-AZ may furnish information concerning my illness and treatment to my insurance carrier(s) in accordance with its privacy policy.

I am advised that any tests (blood work and other specimens) sent to an outside laboratory will result in additional charges that will be billed to my insurance carrier and/or will be billed directly to me by the laboratory.

I also understand that I am responsible for any part of the charges that are not covered by my insurance and I will be billed directly for those services.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Printed Name:_____Relationship to Patient: _____

Signature:_____Date: _____

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Release of Patient Records

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ SSN #: _____

I request and authorize:

Name/Provider: _____

To release healthcare information of the patient named above to:

Name: SWCA-AZ
Address: 1415 Old Weisgarber Rd, Suite 350
City: Knoxville, TN 37909
Phone: 865.936.9480 Fax: 865.224.3200

This request and authorization will apply to other Doctors House Calls operation locations:

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

❑ All healthcare information

_____ _____
Patient Name (Please Print) Relationship to Patient (if not self)

_____ _____
Patient Signature (or Responsible Party) Date

✓ THIS AUTHORIZATION IS IN EFFECT FOR THE DURATION OF YOUR TREATMENT.