INOVA HEALTH SYSTEM

WHC AT FO NEW PATIENT REGISTRATION FORM

**Patient Information:**

Name:_____ Phone:_____
First Middle Last
Street Address: _____
City: _____ State: _____ Zip code: _____
Social Security #: _____/_____/_____ Date of Birth: _____
Sex: M / F Marital Status: Single / Married / Widowed / Separated / Divorced
Are you Currently Employed? Y / N
Employer: _____ Work Phone: _____
Address: _____

**Emergency Contact Information**:

Name: _____
Phone Numbers: Home _____ 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 dependents by the physician 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 fees should this be required.

My preferred method of payment is: Cash____ Check _____ Credit Card_____

Signature: _____ Date: _____

**Assignment and Release**

I, the undersigned, certify that I (or my dependent) have 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 fees should this be required.

Signature: _____ Date: _____

**Inova Mount Vernon Hospital**

**Wound Healing Center**
3700 Joseph Siewick Drive
Fairfax, VA 22033
(703)391-3784

**Referring Dr's Full Name:**_____ **Primary Care Dr's Full Name:**_____

**Date you noticed wound:** ___ / ___ / _____ **Where is wound located?** _____
MM DD YYYY

Is your wound related to an injury at work or car accident? _____

Your Country of Birth:_____ Race:_____ Ethnicity:_____

## Medicare Recipients Only: (Please complete and circle what applies)

**Are you currently receiving care at a Skilled Nursing Facility, Rehab, Assisted Living or Hospice? NO / YES**

1- Is the patient receiving BLACK LUNG benefits? **NO / YES**

2- Are the services to be paid by a government research program? **NO / YES**

3- Are you entitled to benefits through the Department of Veterans Affairs (DVA)? **NO / YES**

4- Are you receiving benefits based on **age** or **disability or End-Stage Renal Disease? (Please circle one)**

5- Are you currently employed? **NO / YES** Is your spouse currently employed? **NO / YES**

**IF** yes to question **5**, do you have health Insurance based on your own employment **NO / YES**, or your spouse current employment status? **NO / YES**

(Please complete **ONLY** if you are **NOT** the Insurance policy holder)

**Primary Ins. Company Name:** _____ **ID#**_____

**SUBSCRIBER'S NAME:** _____

**DOB** ____/_____/_____ **SS#** _____-_____-_____

**RELATION TO PT** _____ **EMPLOYER** _____

**Secondary Ins. Company Name #2** _____ **ID#**_____

**SUBSCRIBER'S NAME** _____ _____

**DOB** ____/_____/_____ **SS#** _____-_____-_____

**RELATION TO PT** _____ **EMPLOYER** _____

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

Please read the statements below. Circle the number in the yes column for those that apply. The clinician will total your score.

1NUTRRE

| | YES |
|---|---|
| Do you have an illness or condition that made you change the kind or amount of food you eat? | 2 |
| Do you eat fewer than two (2) meals a day? | 3 |
| Do you eat few fruits, vegetables, or milk products? | 2 |
| Do you have three (3) or more drinks of beer, liquor, or wine almost every day? | 2 |
| Do you have tooth or mouth problems that make it hard to you to eat? | 2 |
| Do you sometimes not have enough money to buy the food you need? | 4 |
| Do you eat alone most of the time? | 1 |
| Do you take three (3) ore more different prescribed or over-the-counter drugs a day? | 1 |
| Without wanting to, have you lost or gained ten pounds in the last six (6) months? | 2 |
| Are you sometimes not able to physically shop, cook, or feed yourself? | 2 |

***FOR STAFF USE ONLY***

Total the patients score. For proper wound healing the following is recommended.

Total Score: _____

| KEY: | TOTAL SCORE | INTERVENTIONS |
|---|---|---|
| Patient considered low risk for non-healing | 0 - 2 | 1 - 3 |
| Patient considered moderate risk | 3 - 5 | 1 - 5 |
| Patient considered high risk | > 6 | 1 - 4 and 6 - 11 |

**Recommendations Made:**

- ❑ 1. Daily multivitamins
- ❑ 2. Vitamin C 500 mg BID
- ❑ 3. Increased protein and calorie intake
- ❑ 4. Nutritional supplement
- ❑ 5. No signs of wound healing with 2-4 weeks check the following labs
- ❑ 6. Serum Albumin (abnormal < 3.5 mg/dL)
- ❑ 7. Total Lymphocyte count (abnormal < 1,800)
- ❑ 8. Serum Transferrin (abnormal < 200 mg/dL)
- ❑ 9. Serum Pre Albumin (abnormal _____ )
- ❑ 10. Cholesterol
- ❑ 11. Dietician Consult

Date: _____ Staff Signature: _____

PATIENT IDENTIFICATION

**INOVA MOUNT VERNON HOSPITAL**
**WOUND HEALING CENTER**

# NUTRITIONAL SCREEN

CAT #83725 / R041009 • 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):
_____
_____
_____
_____

[redacted]
_____
_____
_____

**MEDICATIONS:**

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

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**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:**
_____
_____

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

83727

1. I hereby authorize Dr. _____ or associates or clinicians of his/her choice at the Wound Healing Center at Inova Mount Vernon Hospital to perform upon me the named patient the following wound care and/or treatment: **WOUND TREATMENT, DEBRIDEMENT AND PHOTOGRAPHS.**

2. The nature and purpose of the wound care and/or other treatment has been fully explained to me and I have been informed of the expected benefits and complications (from known and unknown causes), attendant discomforts and risk that may arise, as well as possible alternatives to the proposed treatment including no treatment. I have been given opportunities to ask questions and all my questions have been answered fully and satisfactorily.

3. I understand that advanced wound healing procedures may be used in my care including the use of skin substitutes. I hereby consent to the use of these wound healing measures and understand that there is a real, but very remote, chance of transmission of infectious disease from these products.

4. Any tissues removed may be examined and retained by the Wound Healing Center at Inova Mount Vernon Hospital for medical, scientific or educational purposes and such tissues or parts may be disposed of in accordance with accustomed practice.

5. I acknowledge that no guarantees or assurance have been made to me concerning the results intended from the wound care and/or treatment.

6. I hereby consent that photographs, tape recordings, videotapes and/or movies may be taken of me (the named patient) by the Wound Healing Center at Inova Mount Vernon Hospital in connection with the medical and other services which I, the patient, am receiving at the Wound Healing Center at Inova Mount Vernon Hospital. I further consent that a history of my/the patient's social and medical problems may be taken by the Wound Healing Center at Inova Mount Vernon Hospital.

7. Such photographs, tape recordings, videotapes, movies and/or histories may be published, shown, exhibited or otherwise used the Wound Healing Center at Inova Mount Vernon Hospital and its authorized affiliate as they may deem proper.

8. I understand that neither myself/the patient nor members of my/the patient's family will be identified by name in connection with any public use of this material.

9. I grant this consent as a voluntary contribution and I waive any and all rights I/patient may have to royalties or other compensation in connection with any such use.

10. I confirm that I have read and fully understand the above and that all blank spaces have been completed prior to my signing. I have crossed out any paragraphs above which do not pertain to me.

| _____ | _____ | _____ |
|---|---|---|
| PATIENT / RELATIVE OR GUARDIAN | DATE | TIME |

_____
RELATIONSHIP, IF SIGNED BY PERSON OTHER THAN PATIENT

| _____ | _____ | _____ |
|---|---|---|
| INTERPRETER (IF REQUIRED) | DATE | TIME |
| WITNESS | DATE | TIME |

The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incompetent to sign.

I hereby certify that I have explained the nature, purpose, benefits, risk of, and alternatives to, the proposed wound care and/or other treatment, have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understand what I have explained and answered.

Physician Signature: _____ Date: _____

PATIENT IDENTIFICATION

**INOVA MOUNT VERNON HOSPITAL**
**WOUND HEALING CENTER**
# CONSENT FOR TREATMENT

CAT #83727 / R121708 • PKGS OF 100

INOVA®


1HIPAA

I certify that I have received Inova's **Notice of Privacy Practices** and that I have a right to receive an additional 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's health care operations. The Notice also describes my rights and Inova'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's web site at www.inova.org. I may request that a copy be mailed to me by calling **703-204-3342.**

Inova 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's web site listed above to view the most current version.

**Patient or Personal Representative** (signature) _____ Date _____ Time _____

**Patient or Personal Representative** (print name) _____

Description of Personal Representative's Authority _____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

CAT #84498 / R052516
PKGS OF 100