VALLEY WOUND CARE SPECIALISTS

NEW PATIENT INFORMATION AND OFFICE POLICY

Dear New Patient,

Welcome to Valley Wound Care Specialists! We are looking forward to working with you to establish a treatment plan so you can get back to feeling your best. Your new patient appointment is scheduled for:

_____

Please bring the attached paperwork with you on your appointment day along with a photo ID, insurance card(s), list of medications you are taking including any over the counter, herbal supplements, list of previous surgeries (if any) and your copayment for your specialist appointment. We will also need the contact information of your PCP or General Practitioner. Your insurance will be verified prior to your visit. If we cannot verify your eligibility your appointment may be rescheduled or you will be offered our discounted cash pay prices. Please also make sure that all records regarding your wound have been forwarded to our office prior to your visit.

Your first visit with us may be with one of our Nurse Practitioners or our Physician Assistant. Dr. Berman may also meet you. Our Team all works together to ensure that you are receiving the best possible treatment.

We do ask that you arrive, with all necessary and completed items listed above, 15 minutes before your scheduled appointment. If you do not have the ability to print and fill out your new patient packet, we ask that you arrive 45 minutes before your scheduled appointment time to allow sufficient time to complete. Failure to arrive on time and or missing documentation may result in your appointment being rescheduled for a later date. We do have a 48-hour New Patient Rescheduling Policy. If you must cancel or reschedule your first visit with us for any reason, we need a minimum of 48 hours notice. There will be a $50.00 charge issued to you if you fail to notify us within this timeframe.

Thank you, we look forward to meeting you.

Sincerely,

Bree Salazar

Bree Salazar
Chief Operating Officer
6320 W Union Hills Drive
Building A, Suite 140
Glendale, AZ 85308
Office- (480) 347-0844
Fax- (480) 347-0885

Find us online: www.valleywoundcare.com

VALLEY WOUND CARE SPECIALISTS

Please fill out this packet to the best of your ability.

Demographics:

Patient Name: _____ Date of Birth: _____ Age: _____

Home address: _____City: _____ State: ____ Zip: _____

Phone number: _____ Home/ Cellular/ Work Email: _____

Emergency Contact Name _____Relationship: _____Phone Number: _____

Pharmacy Name_____ Phone number: _____ Cross Streets: _____

Primary Care Provider: _____ Phone Number: _____

Referring physician: _____ Phone Number: _____

Insurance Plan/Carrier: _____ Insurance Ph number: _____

Insurance ID Number: _____ Insurance Group number: _____

Today's Visit:

Wound Location: _____ Date of Injury: _____

How have you been caring for your wound/prior treatments? _____

_____

Are you currently receiving Home Health? □ No □ Yes Home Health Company name: _____

Home Health Company phone number: _____ Home Health nurse name: _____

Is this related to an accident? □ No □ Yes → □ Auto □ Other _____

Is it work related? □ No □ Yes Workman's Comp Involved? □ No □ Yes

Is there legal action pending regarding this? □ No □ Yes → Attorney Name & Number _____

Physicians involved in your care: Please list all of your current doctors and specialists.

Physician Name	Specialty	Phone Number

Allergies: Are you allergic to medications or foods? □ No □ Yes → list all drug/environmental allergies including adverse reaction:

Allergic to:	Reaction

Some advanced dressings have contents as noted below, please circle if you are allergic to:

Seafood Iodine Sulfa Metals

None of These

Medications: Do we have permission to retrieve your medication history from your pharmacy? □ No □ Yes

Please list all medications including prescription, over the counter, herbs and supplements:

Name	Dose	Frequency

Past Medical History: Have you had or experienced any of the following?

□ No □ Yes Amputation Type:_____
□ No □ Yes Anemia
□ No □ Yes Anxiety
□ No □ Yes Asthma
□ No □ Yes Atrial Fibrillation
□ No □ Yes Bowel Incontinence
□ No □ Yes Coronary Artery Disease
□ No □ Yes Cancer Type:_____
History of chemo or Radiation_____
□ No □ Yes Cardiac Pacer/Defibrillator
□ No □ Yes Osteoarthritis
□ No □ Yes Chronic Foley Catheter
□ No □ Yes Cirrhosis/Liver Disease
□ No □ Yes Collapsed Lung
□ No □ Yes COPD
□ No □ Yes Crohn's Disease/Ulcerative Colitis
□ No □ Yes Cerebral Vascular Accident (Stroke)
□ No □ Yes Depression
□ No □ Yes Diabetes Mellitus Type 1 onset___
□ No □ Yes Diabetes Mellitus Type 2 onset___
□ No □ Yes DVT/Blood Clot
□ No □ Yes Fecal Incontinence
□ No □ Yes Foot Wound
□ No □ Yes Gastric/Duodenal Ulcer
□ No □ Yes Gastrointestinal Disease
□ No □ Yes Gastroesophageal Reflux Disease
□ No □ Yes Gout
□ No □ Yes Heart Failure
□ No □ Yes Heart Murmur
□ No □ Yes Hepatitis
□ No □ Yes High Cholesterol
□ No □ Yes Hypertension
□ No □ Yes Hyperthyroidism
□ No □ Yes Hypothyroidism
□ No □ Yes Implanted devices?_____
□ No □ Yes Kidney Disease (stage ____)
□ No □ Yes Dialysis M T W Th F S

□ No □ Yes Kidney Stones
□ No □ Yes Leg Wounds
□ No □ Yes Multiple Sclerosis
□ No □ Yes Myocardial Infarction
□ No □ Yes Neurogenic Bladder
□ No □ Yes Neurogenic Bowel
□ No □ Yes Neuropathy Location: _____
□ No □ Yes Obesity
□ No □ Yes Obstructive Sleep Apnea
Device in use? No Yes
□ No □ Yes Osteoporosis
□ No □ Yes Paraplegia
□ No □ Yes Peripheral Arterial Disease
□ No □ Yes Prior Flap Reconstruction
□ No □ Yes Progressive Neurological Disorder
□ No □ Yes Pulmonary Disease
□ No □ Yes Quadriplegia
□ No □ Yes Rheumatic Fever
□ No □ Yes Rheumatoid Arthritis
□ No □ Yes Seizures
□ No □ Yes TIA
□ No □ Yes Tuberculosis
□ No □ Yes Urinary Incontinence
□ No □ Yes Valvular Heart Disease
□ No □ Yes Venous Insufficiency

Please List Any Medical Conditions Not Listed Above Here

Other: _____
Other: _____
Other: _____
Other: _____

Preventative Care: (please enter DATES to all that apply)

When was your last:

ABI/TBI: _____
Blood glucose: _____
Echocardiogram: _____
Foot exam: _____
Pneumococcal vaccine: _____
Arterial/Venous Ultrasound: _____
Chest X-ray: _____
Flu Vaccine: _____
HgBA1c %: _____
Routine eye exam: _____

Surgical History:

Date	Procedure

Hospitalizations:

Date	Reason

Family History:

Check appropriate response. Does anyone in your family have history of: add child no history

Unknown History: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling □Child

Bleeding Disorders: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling □Child □ none

Autoimmune Disease: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling □Child □ none

Cancer: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling □Child □ none

Diabetes: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling □Child □ none

Heart Disease: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling □Child □ none

Hereditary Spherocytosis: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling □Child □ none

Hypertension: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling □Child □ none

Kidney Disease: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling □Child □ none

Lung disease: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling □Child □ none

Skin Cancer: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling □Child □ none

Mental illness: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling □Child □ none

Myocardial Infarction: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling □Child □ none

Seizures: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling □Child □ none

Sickle Cell Anemia: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling □Child □ none

Stroke: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling □Child □ none

Tuberculosis: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling □Child □ none

Other: _____ □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling □Child □ none

Social History:

Smoking Status: □ Never Smoked □ Former Smoker □ Current Smoker

How long have you smoked? _____

Amount per day: _____ □ Quit Date:_____ Past amount per day:_____

□ Other Tobacco Use Type: _____

□ Independent
□ Marital Status: _____
□ Occupation: _____
□ Religion: _____
□ Caffeine Use Amount: _____
□ Alcohol Use Amount: _____
□ Illicit Drug Use: _____
□ History of Substance Abuse
□ Mental health concerns
□ In counselling
□ History of Self-Harm
□ Thoughts of Self-Harm
□ Mental health concerns
□ Self Care and Mobility
□ Needs assistance with toileting
□ Needs assistance with transfers

□ Objection to Pork/Fish/Beef/Sheep products
□ Objection to blood and/or human tissue
□ Live Alone
□ Lives with: _____
□ Unable to care for self
□ Assisted Living/Group Home
Name: _____
□ Long Term Care Facility
Name: _____
□ SNF
Name: _____
□ Hospice Care- Name: _____
□ Transportation concerns
□ Needs assistance with dressing
□ Needs assistance with repositioning
□ Requires Some Assistance with Care

Screening:

Fall History

- Have you had any recent falls? □ Yes □ No
- Use any ambulatory aid? □ No □ crutches/cane/walker □ furniture to assist □ chair bound
- Gait: □ Normal □ wheelchair/bedrest □ Weak/Impaired
- Mental status: □ aware of own ability □ forgets to use walking aides

Nutritional Risk Assessment:

- Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?
  □ No Decrease □ Moderate Decrease □ Severe Decrease
- Experienced weight loss during the last 3 months?
  □ more than 6.6lbs □ between 2 to 6 lbs. □ unknown □ no loss
- Mobility □ no limitations □ able to move around home but not outside of home □ bed/chair bound
- Experienced psychological stress or acute disease in past 3 months? □ yes □ no
- Experience problems with mental health
  □ severe depression or dementia □ mild dementia □ no problems

Advanced Care Planning:

Do you have:

Living Will:	□ No □ Yes
DNR/DNI:	□ No □ Yes
Guardian:	□ No □ Yes
Healthcare POA:	□ No □ Yes
Surrogate Decision Maker:	□ No □ Yes

Review of Systems:

Please check all that apply:

GENERAL □ Chills □ Fatigue □ Fever □ Loss of appetite □ Marked weight change □ Night sweats □ Unintentional Weight Loss □ Weakness □ Weight Gain □ Daytime drowsiness □ Difficulty sleeping □ Check box if NO to all	**HEART** □ Chest Pain □ Diaphoresis □ Dyspnea on exertion □ Edema □ Intermittent claudication □ Leg resting pain □ Leg swelling □ Nocturnal dyspnea □ Orthopnea (unable to breathe lying flat) □ Palpitations □ Fainting/Syncope □ Check box if NO to all	**Genito/URINARY** □ Bladder Spasm □ Blood in urine □ Frequency □ Nocturia □ Painful urination □ Decreased force of stream □ Urgency □ Urinary incontinence □ Irregular menstrual cycle □ Abnormal vaginal bleeding □ Pregnant □ Check box if NO to all	**MUSCLE/JOINTS** □ Assistive Devices □ Backache □ Contracture □ Decreased Activity □ Deformities □ Joint Pain □ Joint Swelling □ Muscle Pain □ Muscle Wasting □ Muscle Weakness □ Check box if NO to all
EYES □ Blurred Vision □ Discharge/drainage □ Double Vision/Spots/Flashing lights □ Dry eyes □ Excessive tearing □ Eye pain □ Glasses / Contacts □ Partial /Complete blindness □ Sensitivity to light □ Vision changes □ Check box if NO to all	**LUNGS** □ Cough □ Hemoptysis (coughing up blood) □ Shortness of Breath □ Wheezing □ Oxygen in use □ Painful breathing □ Check box if NO to all	**ENDOCRINE** □Cold/heat intolerance □ Excessive Thirst □ Excessive Hunger □ Excessive Urination □ Check box if NO to all	**BLOOD** □ Bleeding/Clotting Disorder □ Easy Bleeding □ Blood Transfusion □ Bruising □ Enlarged Lymph Nodes □ Swelling □ Swollen glands □ Check box if NO to all
EAR/NOSE/MOUTH/THROAT □ Bleeding gums □ Current infection □ Dental problems □ Difficultly clearing ears □ Halitosis □ Hearing loss/Aid □ Hoarseness □ Ear Pain □ Frequent Cold □ Loss of Smell/Taste □ Nasal congestion □ Nose Bleeds □ Painful or Swollen lymph nodes □ Post Nasal Drip □ Sore Throat □ Check box if NO to all	**STOMACH/COLON** □ Acid Reflux □ Bloody Stools □ Bowel Incontinence □ Change in bowel habits □ Constipation □ Diarrhea □ Difficulty swallowing □ Hemorrhoids □ Indigestion □ Jaundice □ Loss of appetite □ Nausea/vomiting/diarrhea □ Rectal bleeding □ Stomach/abdominal pain □ Vomiting blood □ Check box if NO to all	**NEUROLOGIC** □ Abnormal Gait □ Dizziness □ Headache □ Loss of protective sensation □ Memory loss □ Numbness □ One sided weakness □ Pain from neuropathy □ Paralysis □ Seizures □ Spasms □ Syncope □ Tingling □ Tremors □ Weakness □ Check box if NO to all	**SKIN** □ Change: Hair, Nails, Skin □ Dryness □ Callous/corn □ Change in moles □ Hemosiderin staining/ hyperpigmentation □ Itching □ Lesions □ Lumps □ Skin allergies □ Sun sensitivity □ Ulcers/open sore □ Prone to skin tears □ Rash □ Check box if NO to all

MENTAL HEALTH □ Anxiety □ Claustrophobia □ Depression □ Insomnia □ Mental illness □ Memory loss □ Nervousness / Tension □ Restraints □ Suicidal □ Check box if NO to all	**ALLERGIC** □ Frequent rashes □ Hay Fever □ Hives □ Rhinitis □ Recurrent fevers □ Check box if NO to al		

Anything else you would like your provider to know or be aware about?

_____
_____
_____
_____
_____
_____

Preferred Confidential Communication

□ By checking this box, I give my consent for Valley Wound Care Specialists and their staff to leave specific personal health information (test results, appointment scheduling, billing issues, etc.) on my voicemail and/ or text at: (____) _____-_____

□ By checking this box, I give my consent for Valley Wound Care Specialists and their staff to leave specific personal health information (test results, appointment scheduling, billing issues, etc.) with listed person below
Name: _____ Relation: _____ phone (____) _____-_____

I attest that the information provided is accurate and described to the best of my ability.

_____

Signature Date

_____

Printed Name

VWCS Notes:

_____
_____
_____
_____
_____

VALLEY WOUND CARE SPECIALISTS

Conditions of Treatment

Consent to Medical, Wound and Related Healthcare: I agree to the treatment for medical care and the treatment and/or procedures that my doctor thinks are needed. I understand that my doctor will decide on the care I receive at Valley Wound Care Specialists.

Medical and Allied Health Care Providers: I understand that my care will be provided by Physicians and/or Allied Health Providers (Nurse Practitioners and Physician Assistants). Everyone will work under a supervising physician and work together and aim for positive patient outcomes.

Teaching Programs: Valley Wound Care Specialists has agreements with medical schools that teach medicine to future doctors, nurses and other health professionals. I understand that medical students, nursing students and/or other health profession students may assist with my care.

Consent for Photography: I consent to having my photograph taken for identification purposes. It is our office policy to confirm your identity prior to providing medical care. I consent to photographs taken during my medical and surgical care for the use of tracking my wound healing progress and before/after comparison. The term "photograph" includes both video and still photography in a digital format. I hereby grant permission to Valley Wound Care Specialists to use photographs of my wound, digital images, and/or digital files of my wound(s) for use anonymously in but not limited to: marketing materials, wound healing progress, and/or educational materials. These materials might include printed or electronic publications, web sites or other electronic communications. I authorize the use of these images without compensation to me. All negatives, prints, digital reproductions and files shall be the property of Valley Wound Care Specialists.

Release of Information: I understand that Valley Wound Care Specialists will treat my medical information as confidential; however, I understand that information will be shared with other providers directly involved in my care or involved in the payment for my care. I agree to the release of information in my medical record as needed to and from Valley Wound Care Specialists.

Assignment of Benefits: I authorize payment to Valley Wound Care Specialists for any types of payment due from Medicare, Medicaid, Commercial insurance or any other third-party payer.

Payment: I agree to pay copayments, co-insurances and/or deductibles at the time services are rendered. I understand that this payment may be in the form of cash, check with identification, and major credit cards (Visa, MasterCard, Discover, or American Express.)

Advanced Directives: I understand that if I have any advanced directives, Living Will or healthcare Power of Attorney, I will provide a copy to Valley Wound Care Specialists to be kept on file should it need to be referenced.

_____ _____

(Patient Signature) (Date)

_____

(Printed Name)

VALLEY WOUND CARE SPECIALISTS

Care Agreement

Agreement to receive wound care between: VALLEY WOUND CARE SPECIALISTS and:

_____

(Patient Name)

I understand that in order for my wound healing treatment to prove effective, I must comply and adhere to the treatment outlined by my provider. Treatment is most effective on a regular reoccurring basis and I understand that missed or sporadically attended appointments are not best for my healing.

I understand that in order for me to receive wound care treatment from Valley Wound Care Specialist, I agree to the following conditions:

1. I will appear for treatment appointments as scheduled.
2. I will follow my treatment regimen as prescribed for me to the best of my ability.
3. I will inform Valley Wound Care Specialists if I find myself unable to comply.
4. If I am unable to make a scheduled appointment, I will notify Valley Wound Care Specialists as soon as possible and I will also try to reschedule per my treatment plan.
5. I will not miss more than 2 days of treatment during my treatment plan.
6. I understand that a violation of these conditions may result in my discharge from Valley Wound Care Specialists.
7. I understand that there may be fees associated with my care.
   $35.00- NSF/ Returned Check
   $35.00- No Show Appointment Fee- When you are not present for your scheduled appointment.
   $25.00- Same Day Reschedule. We do require that you provide 24 hours' notice when rescheduling. A fee will be issued if you reschedule or cancel within 24 hours of your scheduled visit.
   $35.00- Paperwork completion: Disability forms/ FMLA/ HR/ Other forms

I accept the above terms as a condition of my receiving treatment at Valley Wound Care Specialists.

_____ _____

(Patient Signature) (Date)

_____ _____

(Printed name) (Phone number)

VALLEY WOUND CARE SPECIALISTS

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information. The Notice contains your Patient Rights that describes your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

_____ _____

(Patient Signature) (Date)

_____

(Printed Name)

Witness: _____ _____

(Practice Representative) (Date)

VALLEY WOUND CARE SPECIALISTS

Patient Portal Enrollment Form

Due to new Federal Regulations, our practice is required to enroll you in our Patient Portal. Our Portal is a secure website that will allow you to access your medical record and communicate with us about your health and wound management.

To enroll you in our Portal, we need your email address. As always, we will treat your email address as confidential. It's use will only be used for communication with you about your care.

Our staff will print you a paper invite code which you will use for the first-time set-up. If you have any questions, please let one of our Staff Members know.

Today's Date: _____

Patient Name: _____

Date of Birth: _____

Email address: _____

Patient Signature: _____

VALLEY WOUND CARE SPECIALISTS

WOUND DEBRIDEMENT CONSENT

This consent form provides a written communication of the recommended surgical procedure(s) to be performed. It will allow you to give or withhold your consent to the proposed procedure(s).

Patient Name: _____

1. Procedure(s) proposed:

☐ Conservative Sharp Debridement/Non-Excisional Debridement: which is removing necrotic or dead tissue from the existing wound to promote granulation to facilitate wound healing. During the debridement process, further exploration of the wound site may require the more invasive Excisional Wound Debridement as described below.

☐ Excisional Wound Debridement: which is removing necrotic or dead tissue along with viable tissue surrounding the existing wound to promote granulation to facilitate wound healing.

Procedure site(s):_____

Performed by: Dr. Michael L Berman, Kristina Fawcett NP-C, Kurt Holifield NP-C, Alona Milshteen NP-C, Camile Solidum NP-C, Scott Villaneuva PA-C, Pamela Waychoff NP-C

Type of anesthesia: ☐ None ☐ Local ☐ Other _____

2. Risks/Benefits:

All surgical procedures involve risks and benefits and no guarantee is made as to result or cure. You have the right to be informed of the proposed procedure(s): benefits, side effects of the proposed procedure(s), the likelihood of achieving treatment goals, reasonable alternatives, side effects of the alternatives, and possible results of not receiving care or treatment. The following additional risks and potential complications may occur in connection with this particular procedure: Blood loss requiring blood transfusion, nerve damage, and damage to healthy tissue. If your provider determines that there is a reasonable possibility that you may need a blood transfusion as a result of the procedure to which you are consenting, your doctor will inform you of this and will provide you with information concerning the benefits and risks of the options for blood transfusion.

3. Authorization and Consent: Your signature on this form indicates that:

- You have read and understand the information provided in this form.
- Your provider has adequately explained to you the proposed procedure(s) and the anesthesia set forth above. The discussion included the risks, benefits, consequences, alternatives and other pertinent information and you do not need further explanation.
- You have had a chance to ask your provider(s) questions and obtain answers to your satisfaction.
- You authorize and consent to the performance of the proposed procedure(s) and anesthesia.
- You impose no specific limitations regarding the use or disposal of any tissue removed during the procedure.

Patient Signature: _____ Date: _____

Printed Name: _____

PROVIDER CERTIFICATION: I hereby certify that I have discussed the procedure(s) described above with the patient (or patient's legal representative). The discussion was held prior to procedure and included the risks/benefits, consequences/alternatives and other pertinent information about the proposed procedure(s).

Provider Signature _____ Date: _____

VALLEY WOUND CARE SPECIALISTS

Dr. Michael L. Berman, DO, CWSP, FACCWS, FAPWH
Kristina Fawcett DNP, NP-C, CWS
Kurt Holifield NP-C
Alona Milshteen NP-C, CWS
Camile Solidum NP-C
Scott Villanueva PA-C, CWS
Pamela Waychoff NP-C, CWON-AP

Phone: 480-347-0844 **Fax: 480-347-0885**

Welcome to Valley Wound Care Specialists!

We are located in:

Glendale 6320 W Union Hills Dr. Building A, Suite #140 Glendale, AZ 85308	**Sun City** 14642 N Del Webb Blvd. Suite 200 Sun City, AZ 85351
Please note that we are Building "A" in this plaza and there is additional parking to the East of the building.	
Please see the below map for directions and please feel free to call with any questions!	Please see the below map for directions and please feel free to call with any questions!