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
Office Manager
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
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 & Phone Number: _________________________________
Pharmacy Name/Phone number: ___________________________ Cross Streets: ______________
Primary Care Provider: ____________________________ Referring physician: ____________________________
Insurance Plan/Carrier: ____________________________ Insurance Ph number: ____________________________
Insurance ID Number: ____________________________ Insurance Group number: ________________

Today’s Visit:
Reason for today’s visit: ____________________________ When did symptoms start: _________________
Is it work related? □ No □ Yes Workman’s Comp Involved? □ No □ Yes
Is this related to an accident? □ No □ Yes → □ Auto □ Other ____________________________
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.

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<thead>
<tr>
<th>Physician Name</th>
<th>Specialty</th>
<th>Phone Number</th>
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**Allergies**: Are you allergic to anything? □ No □ Yes → list all drug/environmental allergies including adverse reaction:

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<tr>
<th>Allergic to:</th>
<th>Reaction</th>
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**Medications**: Please list all medications including prescription, over the counter, herbs and supplements:

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<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Frequency</th>
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Past Medical History: Have you had/experienced any of the following?

☐ No ☐ Yes  Amputation  Type:___________  ☐ No ☐ Yes  Kidney Stones
☐ No ☐ Yes  Anemia  □ No ☐ Yes  Leg Wounds
☐ No ☐ Yes  Anxiety  ☐ No ☐ Yes  Multiple Sclerosis
☐ No ☐ Yes  Asthma  ☐ No ☐ Yes  Myocardial Infarction
☐ No ☐ Yes  Atrial Fibrillation  ☐ No ☐ Yes  Neurogenic Bladder
☐ No ☐ Yes  Bowel Incontinence  ☐ No ☐ Yes  Neurogenic Bowel
☐ No ☐ Yes  Coronary Artery Disease  ☐ No ☐ Yes  Neuropathy  Location: __________
☐ No ☐ Yes  Cancer  Type:____________  ☐ No ☐ Yes  Obesity
☐ No ☐ Yes  Cardiac Pacer/Defibrillator  ☐ No ☐ Yes  Obstructive Sleep Apnea
☐ No ☐ Yes  Congestive Heart Failure  ☐ No ☐ Yes  Osteoarthritis
☐ No ☐ Yes  Chronic Foley Catheter  ☐ No ☐ Yes  Osteoporosis
☐ No ☐ Yes  Cirrhosis  ☐ No ☐ Yes  Paraplegia
☐ No ☐ Yes  Colitis  ☐ No ☐ Yes  Pain Pump
☐ No ☐ Yes  COPD  ☐ No ☐ Yes  Peripheral Arterial Disease
☐ No ☐ Yes  Crohn’s Disease  ☐ No ☐ Yes  Prior Flap Reconstruction
☐ No ☐ Yes  Cerebral Vascular Accident (Stroke)  ☐ No ☐ Yes  Progressive Neurological Disorder
☐ No ☐ Yes  Depression  ☐ No ☐ Yes  Pulmonary Disease
☐ No ☐ Yes  Diabetes Mellitus Type 1  ☐ No ☐ Yes  Quadriplegia
☐ No ☐ Yes  Diabetes Mellitus Type 2  ☐ No ☐ Yes  Rheumatic Fever
☐ No ☐ Yes  DVT/Blood Clot  ☐ No ☐ Yes  Rheumatoid Arthritis
☐ No ☐ Yes  Fecal Incontinence  ☐ No ☐ Yes  Seizures
☐ No ☐ Yes  Foot Wound  ☐ No ☐ Yes  TIA
☐ No ☐ Yes  Gastric/Duodenal Ulcer  ☐ No ☐ Yes  Tuberculosis
☐ No ☐ Yes  Gastrointestinal Disease  ☐ No ☐ Yes  Urinary Incontinence
☐ No ☐ Yes  Gastroesophageal Reflux Disease  ☐ No ☐ Yes  Valvular Heart Disease
☐ No ☐ Yes  Gout  ☐ No ☐ Yes  Venous Insufficiency
☐ No ☐ Yes  Heart Murmur
☐ No ☐ Yes  Hepatitis  Other: ______________________________
☐ No ☐ Yes  High Cholesterol  Other: ______________________________
☐ No ☐ Yes  Hypertension  Other: ______________________________
☐ No ☐ Yes  Hyperthyroidism
☐ No ☐ Yes  Hypothyroidism  Other: ______________________________
☐ No ☐ Yes  Insulin Pump
☐ No ☐ Yes  Kidney Disease  Other: ______________________________
☐ No ☐ Yes  Dialysis  M  T  W  Th  F  S

Hospitalizations:

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<th>Date</th>
<th>Reason</th>
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Surgical History:

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<tr>
<th>Date</th>
<th>Procedure</th>
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Social History:
Smoking Status: □ Never Smoked □ Current Smoker How long have you smoked?__________ Amount per day:__________ □ Quit Date:__________ Past amount per day:__________
□ Other Tobacco Use Type:______________
□ Independent □ Live Alone
□ Marital Status: ______________________ □ Lives with: ________________________________________________
□ Occupation: ________________ □ Retired
□ Religion: ____________________________ □ Requires Some Assistance with Care
□ Caffeine Use Amount:_________________ □ Unable to care for self
□ Alcohol Use Amount:_________________ □ Assisted Living/Group Home Name:___________________________
□ Illicit Drug Use _______________________ □ Long Term Care Facility Name:___________________________
□ Hx Substance Abuse □ SNF Name:___________________________
□ Hospice Care- Name:__________________
□ Mental health concerns □ Transportation concerns
□ In counselling □ Self Care and Mobility
□ Hx of Self-Harm □ Needs assistance with dressing
□ Thoughts of Self-Harm □ Needs assistance with toileting
□ Needs assistance with repositioning □ Needs assistance with transfers

Preventative Care: (please enter DATES to all that apply) When was your last:
ABI/TBI: ____________________________ Arterial/Venous Ultrasound: ____________________________
Blood glucose: _______________________ Chest X-ray: ____________________________
Echocardiogram: _____________________ Flu Vaccine: ____________________________
Foot exam: __________________________ HgBA1c %: ____________________________
Pneumococcal vaccine:________________ Routine eye exam: ____________________________

Family History:
Check appropriate response. Does anyone in your family have history of:
Unknown History: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling
Bleeding Disorders: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling
Autoimmune Disease: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling
Cancer: □Mother □Maternal Grandparent □Father □Paternal Grandparents □Sibling
### Review of Systems:
Please check all that apply:

<table>
<thead>
<tr>
<th>GENERAL</th>
<th>HEART</th>
<th>URINARY</th>
<th>MUSCLE/JOINTS</th>
<th>NEUROLOGIC</th>
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<tbody>
<tr>
<td>□ Unexpected Weight Loss</td>
<td>□ Chest Pain</td>
<td>□ Frequency</td>
<td>□ Joint Pain</td>
<td>□ Dizziness</td>
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<tr>
<td>□ Weight Gain</td>
<td>□ Murmurs</td>
<td>□ Urgency</td>
<td>□ Stiffness</td>
<td>□ Tremors</td>
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<tr>
<td>□ Fever</td>
<td>□ Fainting</td>
<td>□ Bleeding</td>
<td>□ Joint Swelling</td>
<td>□ Unsteady Gait</td>
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<tr>
<td>□ Fatigue</td>
<td>□ Palpitations</td>
<td>□ Difficult/Painful Uribation</td>
<td>□ Joint Instability</td>
<td>□ Seizure</td>
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<tr>
<td>□ Chills</td>
<td>□ Other</td>
<td>□ Other</td>
<td>□ Redness</td>
<td>□ Numbness/Tingling</td>
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<tr>
<td>□ Other</td>
<td>□ Check box if NO to all</td>
<td>□ Check box if NO to all</td>
<td>□ Muscle Pain</td>
<td>□ Other</td>
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<tr>
<th>EYES</th>
<th>LUNGS</th>
<th>ENDOCRINE</th>
<th>BLOOD</th>
<th>SKIN</th>
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<tr>
<td>□ Blurred Vision</td>
<td>□ Shortness of Breath</td>
<td>□ Excessive Thirst</td>
<td>□ Easy Bleeding</td>
<td>□ Redness</td>
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<tr>
<td>□ Double Vision</td>
<td>□ Snoring</td>
<td>□ Heat/Cold Intolerance</td>
<td>□ Bruising</td>
<td>□ Rash</td>
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<td>□ Corrective Lens</td>
<td>□ Coughing</td>
<td>□ Excessive Urination</td>
<td>□ Blood Clots</td>
<td>□ Itching</td>
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<td>□ Eye Pain</td>
<td>□ Wheezing</td>
<td>□ High Blood Sugar</td>
<td>□ Anemia/Low Blood Counts</td>
<td>□ Poor Healing</td>
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<tr>
<td>□ Eye Redness</td>
<td>□ Coughing Blood</td>
<td>□ Other</td>
<td>□ Other</td>
<td>□ Skin Changes</td>
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<td>□ Watering</td>
<td>□ Other</td>
<td>□ Check box if NO to all</td>
<td>□ Check box if NO to all</td>
<td>□ Other</td>
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<th>MENTAL HEALTH</th>
<th>ALLERGIC</th>
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<td>□ Anxiety</td>
<td>□ Foods</td>
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<td>□ Nervousness</td>
<td>□ Dust</td>
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<td>□ Depression</td>
<td>□ Pollen</td>
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<tr>
<td>□ Hallucinations</td>
<td>□ Hay Fever</td>
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<td>□ Other</td>
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Screening:
Fall History
Have you had any recent falls? Yes / No If yes- when? _______________________________

Depression
Have you recently been feeling depressed with little interest in doing things, feeling down or hopeless? Yes / No
Are you currently under the care of a counselor, psychiatrist, or social worker? Yes / No If Yes: __________________

Abuse
Have you in the past or currently been the victim of physical or sexual abuse? Yes / No

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

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

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

__________________________________________________________________________________________________
Signature Date

Printed Name

VWCS Notes:
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. I consent to photographs taken during my medical and surgical care for the use of tracking my wound healing progress. 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, digital images, and/or digital files of me and/or 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.

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)
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.

The recommended treatment program by Valley Wound Care Specialists is to be seen ___________________.
(Frequency)

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)
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)
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: __________________________________________________________________________________________________________

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).

Signed: _________________________________________________________________ Date: _____________________
Welcome to Valley Wound Care Specialists!

We are located at:
6320 W Union Hills Dr.
Building A, Suite #140
Glendale, AZ 85308

*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!