PATIENT REGISTRATION FORM

Patient Name | Date

Address

Home Phone | Cell Phone | Email

Employer | Employer Phone Number

SSN | DOB

Race | Gender | Language

Spouse Name | Spouse DOB

Spouse Employer | Spouse Work Number | Spouse SSN

Referring Provider | Provider Location and Phone Number

Primary Insurance | Policy Holder

Emergency Contact Name | Phone Number

Address

FINANCIAL AGREEMENT

WHEN COLLECTION EFFORTS OVER AND ABOVE THE NORMAL BILLING ARE REQUIRED, AN ADDITIONAL SERVICE CHARGE MAY BE ASSESSED. AN ADDITIONAL CHARGE WILL BE ASSESSED FOR ALL CHECKS RETURNED FOR INSUFFICIENT FUNDS. THE OFFICE CANNOT ACCEPT RESPONSIBILITY FOR COLLECTION OF INSURANCE, OR OTHER CLAIMS. YOU ARE RESPONSIBLE FOR PAYMENT ON YOUR ACCOUNT IN ACCORDANCE WITH OUR POLICY. WE ANTICIPATE PAYMENTS ON YOUR ACCOUNT EVEN THOUGH YOU MAY HAVE AN INSURANCE CLAIM PENDING.

RELEASE OF INFORMATION

YOUR SIGNATURE AUTHORIZES UTAH WOUND CARE AND HYPERBARIC CENTER TO RELEASE MEDICAL INFORMATION THAT MAY BE NECESSARY TO REQUEST CLAIM REIMBURSEMENT FROM INSURANCE COMPANIES OR OTHER PAYERS TO WHOM CLAIMS HAVE BEEN SUBMITTED AND TO RELEASE CREDIT INFORMATION GATHERING AGENCIES.

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO UTAH WOUND CARE AND HYPERBARIC CENTER OR AGENTS. YOUR SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF ANY INFORMATION NECESSARY TO PROCESS THE CLAIM. IN CASE OF A MEDICARE CLAIM, THE PATIENT'S SIGNATURE AUTHORIZES ANY ENTITY TO RELEASE TO MEDICARE MEDICAL AND NON-MEDICAL INFORMATION, INCLUDING EMPLOYMENT STATUS, AND WHETHER THE PERSON HAS EMPLOYER GROUP HEALTH INSURANCE, LIABILITY, NO-FAULT, WORKERS COMPENSATION OR OTHER INSURANCE WHICH IS RESPONSIBLE TO PAY FOR THE SERVICES FOR WHICH THE MEDICARE CLAIM MADE.

PATIENT SIGNATURE: ______________________________ **DATE:** ____________________

Utah Wound Care and Hyperbaric Center

209 E Gordon Ave. Ste 1 & 2, Layton, Utah 84041

Consent and Conditions of Treatment

As either the Patient or the legally authorized representative of the Patient, the following consents, understandings, and agreement are made on my own behalf or on the behalf of the Patient in partial consideration of the health care services to be provided to the Patient at the Utah Wound Care and Hyperbaric Center ("Facility"):

1. **Consent for Services.** On behalf of the Patient, consent is hereby given to the Facility, its independent contractors (see 2.b, below), medical staff, and employees to provide health care services to the Patient, to administer physician orders for the benefit of the Patient, and to provide all related care and services to Patient while in the Facility, including but not limited to all routine and non-routine tests and studies ordered in the belief that they are medically necessary or appropriate for the Patient. See also, 2.a, below. It is understood that Facility services, medical care, and surgery are not exact sciences and that there is a risk of substantial and serious harm involved in such treatments and services, and such risk is accepted in the hope of obtaining beneficial results from such services. It is understood that the Patient and his/her legally authorized representatives have the right to ask questions and to receive answers to such questions about the Patient's condition and the health care services. At this time, all such questions, if any, have been satisfactorily answered. No promises of any particular outcome or successful result have been made, it being understood and accepted that there is some uncertainty involved in health care services for which consent is given.

2. **Miscellaneous agreements and understandings:**
   a. **Medical Education.** Permission is given for persons involved in medical education to be present and/or participate when the Patient receives health care services. Student will be directly supervised by the Physician or staff employees from whom they are receiving training or education.

   b. **Independent Contractors.** It is understood that many physicians and other health care providers furnishing services to the Patient, including residents and interns, are independent contractors or medical students and are not Facility agents or employees. It is agreed that the Facility is not responsible or liable for the actions or interactions of persons who are not Facility employees.

   c. **Personal Property.** It is understood that the Facility is not responsible for personal property.

   d. **Release of Information.** The law requires the Facility to make and keep records of the Patient's medical treatment. The Facility safeguards those records and it uses and discloses such records and the information they contain only in accordance with State and Federal privacy laws. Such uses and disclosures are described in detail in the Facility's Notice of Privacy Practices, which are amended from time to time.

   e. **Assignment of Benefits.** Any and all benefits from insurance companies and other third party payers that are payable to the Patient or on behalf of the Patient for health care services, and all related payments for services rendered or provided to the Patient in the Facility are hereby transferred and assigned to the Facility for the exclusive purpose of obtaining payment for charges associated with health care services provided to the Patient in the Facility. It is understood and agreed that all insurance companies and other third party payers will pay benefits directly to Facility in payment of Facility's charges.

   f. **Financial Responsibility.** Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay for all health care services rendered to the Patient in the Facility including, but not limited to any amounts not paid by any insurance company or other third party payer. It is understood that the Patient and the undersigned are also responsible to pay all applicable co-payments, deductibles, co- insurance and all charges for non-covered services. It is understood and agreed that charges not paid in a timely fashion will be placed for collection with a collection agency. A $20 service charge will be assessed for any retuned check or other tender not payable.

g. **Patient's Certification for Government Health Care Programs.** I certify that the information given in applying for payment for Medicare, Medicaid, Tricare, or any other government program for payment under Titles XVIII and XIX of Social Security Act or otherwise, is correct. I authorize any holder of medical or other information about me to release to the Tricare administrator, Social Security Administration or its intermediaries, or other carriers or program administrators, or to the State or any other payer, any information needed to substantiate and process a claim for payment for this or any related service. I request that payment of authorized charges be made in my behalf directly to the Facility for its charges and for any charges of physicians or other providers for whom the Facility is authorized to bill in connection with its services.

h. **Consent for photographs.** It is understood that in the interest of preserving accurate identification, it may be necessary to obtain facial and/or profile photographs. Photographs or other digital images may be recorded to document for care. I understand that Utah Wound Care and Hyperbaric Center will retain ownership rights to these photographs or other images, but that I will be allowed access to view them or obtain copies. Such photographs will become part of the Patient's medical record. These photographs will be safeguarded as described in 2.d, above.

i. **Communication and contact.** You authorize us to call you at any number you provide or at any number at which we reasonably believe we can contact you, including calls to home, mobile, cellular, or similar devices and other places you may reside or work for any lawful purpose, including and not limited to the emergency contact information provided by you.

The undersigned signs this document either as the Patient or as the agent or representative of the Patient authorized to execute this document and to accept and agree to its terms on behalf of the Patient. I have read the foregoing and have had the opportunity to ask any questions I may have about the foregoing. Such questions have been answered to my satisfaction, and I indicate my understanding of what I am agreeing to by signing below. I understand that I am entitled to request and obtain a copy of this document.

Beginning July 7, 2022 the following provision applies: I hereby acknowledge that I have received or been offered a copy of the Facilities Notice of Privacy Practices.

______________________________ ______________________________

Patient's Name (printed) **Date signed**

X______________________________ ______________________________

Patient's signature or Representative's signature **Representative's Name & relationship to patient**

Staff Member witness: X______________________ **Chart/Acct #______________________**

Utah Wound Care and Hyperbaric Center

HIPPA Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.
6. Your confidential information will <u>not</u> be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ________________________________, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward

Patient Signature____ **Date:** ____________________

Utah Hyperbaric Center

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEGDEMENT

A Notice of Privacy Practices (NPP) is provided to all patients and explains: (1) how your Protected Health Information (PHI) may be used or shared; (2) your rights to access or amend your PHI, request information on disclosures of your PHI, and request additional restrictions on our uses and disclosures of PHI; (3) your rights to complain if you believe your privacy rights have been violated; and (4) our responsibilities for maintaining the privacy of your PHI.

- I acknowledge that I have read the foregoing and received a copy of the “Notice of Privacy Practices” (Dated July 7, 2022) that explains when, where, and why my Protected Health Information (PHI) may be used or shared.
- I authorize Utah Wound Care and Hyperbaric Center to furnish complete information, including Protected Health Information, requested by my insurance carrier or its intermediaries regarding services rendered. I hereby authorize my insurance carrier to furnish Utah Wound Care Center any information obtained in the adjudication of any claim for services furnished to me by Utah Wound Care and Hyperbaric Center.
- I acknowledge that Utah Wound Care and Hyperbaric Center, the physicians, the nurses, and other staff may obtain and share any or all of my Protected Health Information, including prescription history, with other health care professionals in order to treat me, coordinate my care, and/or in order to arrange for payment of my bill and respond to any issues related to my care.
- I acknowledge that I have the right to request additional restrictions on the use and disclosure of my PHI if I so choose.

Printed Name of Patient: ____ DOB:______________________

Signature of Patient/Guardian: ____ Date:__________

Printed Name of Guardian/Representative: ____

Relationship to Patient: ____

Patient Communication Consent

We may need to contact you regarding your medical care, appointments, test results, referrals, or any other reason. This is to acknowledge that you authorize **Utah Wound Care and Hyperbaric Center** to contact you and how you wish to be contacted (check all that apply):

	ORDER OF PREFERENCE:	OK TO LEAVE VOICEMAIL?	PHONE NUMBER:
HOME PHONE	❒1 ❒2 ❒3 ❒4 ❒5	❒YES ❒NO	
CELL PHONE	❒1 ❒2 ❒3 ❒4 ❒5	❒YES ❒NO	
WORK PHONE	❒1 ❒2 ❒3 ❒4 ❒5	❒YES ❒NO	
ALTERNATE PHONE	❒1 ❒2 ❒3 ❒4 ❒5	❒YES ❒NO	
SECURE EMAIL	❒1 ❒2 ❒3 ❒4 ❒5	EMAIL ADDRESS:	
☐ None of the above			

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical care or financial matters. This is to acknowledge that you authorize **Utah Wound Care and Hyperbaric Center** to disclose your PHI to the following individuals (check all that apply):

Name:____ Relationship to Patient:___________________________

Telephone: ______________________________________ Email: ______________________________________

Types of Information: ❒ Appointment Reminders ❒ Results (lab test, X-Ray, etc) ❒ Financial ❒ Any/All May contact via: ❒ Telephone ❒ Leave a Voice Mail ❒ Secure Email ❒ Other: _____________________

Name:____ Relationship to Patient:___________________________

Telephone: ______________________________________ Email: ______________________________________

Types of Information: ❒ Appointment Reminders ❒ Results (lab test, X-Ray, etc) ❒ Financial ❒ Any/All May contact via: ❒ Telephone ❒ Leave a Voice Mail ❒ Secure Email ❒ Other: _____________________

Name:____ Relationship to Patient:___________________________

Telephone: ______________________________________ Email: ______________________________________

Types of Information: ❒ Appointment Reminders ❒ Results (lab test, X-Ray, etc) ❒ Financial ❒ Any/All May contact via: ❒ Telephone ❒ Leave a Voice Mail ❒ Secure Email ❒ Other: _____________________