YUKON WOUND CARE AND REHABILITATION

REGISTRATION FORM (PLEASE PRINT)

NAME:_____DATE:_____

BIRTHDAY:_____SEX: MALE / FEMALE SSN:_____

HOME PHONE:_____CELL:_____WORK:_____

CIRCLE ONE: STUDENT / UNEMPLOYED / DISABLED / RETIRED / EMPLOYER:_____

MARITAL STATUS: SINGLE / MARRIED / WIDOWED / OTHER:_____

ADDRESS:_____ID ON FILE: Y / N

CITY:_____STATE:_____ZIP CODE:_____

EMAIL:_____

DOCTOR(S): _____

EMERGENCY CONTACT:

EMERGENCY CONTACT PERSON:_____

RELATIONSHIP TO PATIENT:_____PHONE NUMBER:_____

INSURANCE INFORMATION: ***COMPLETE ONLY IF YOU ARE NOT THE POLICY HOLDER***

INSURANCE COMPANY:_____CARD ON FILE: Y / N

ID#:_____ GROUP#:_____

INSURED/POLICY HOLDER NAME:_____**SEX: MALE / FEMALE**

BIRTHDAY:_____**SSN:**_____

EMPLOYER:_____**WORK PHONE:**_____

YUKON WOUND CARE AND REHABILITATION

CONSENT FOR CARE

I authorize YWCR to furnish my insurance company or its representative, any information needed for claims/billing purposes. I authorize payment for these services directly to YWCR for all charges. I agree to pay any/all charges, whether covered or not by my insurance, to include any fees associated with debt collection. YWCR or its billing service may check credit with a source to obtain my credit information. I authorize any holder of my medical information to release the information needed for my care or to determine benefits payable for related services. This release may include information which could be considered a communicable disease such as hepatitis, syphilis, and/or human immunodeficiency virus HIV/AIDS. I consent to all tests, treatments and procedures provided by YWCR. I grant the requested authorizations and state the information I have provided is accurate to the best of my knowledge.

INJURY / THIRD PARTY LIABILITY & HOME HEALTH

If your therapy is due to an injury where a third party may be liable, you could be responsible for charges at the full-pay rate (subsequent to non-payment or recoupment by your insurance carrier). If you are receiving home health, your insurance cannot be billed for therapy services; you will be responsible for charges at the self-pay/discounted rate. Please inquire about a third-party / self-pay contract if needed.

CANCELLATION / NO-SHOW POLICY

There will be a $25 charge for all No-Show / No-Call appointments or same day cancelations. If you will be late or must cancel due to *EMERGENCY* circumstances, please contact us ASAP. If you are more than 15 minutes late for an appt, it may need to be rescheduled.

Deductibles, Co-Pays & Co-Insurance Payments are Due at Time of Service

My signature below indicates that I have read and understand the above. A photo copy of this authorization shall be considered as valid as the original.

_____ **Date:**_____

Signature of Patient / Parent or Guardian

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RELEASE OF INFORMATION

YWCR will not discuss, or release your protected health care information to individuals (other than your health care provider) unless authorized. If you wish to have your medical info/records discussed or released to **someone other than your primary care/referring provider**, please fill out the following:

I, _____, (patient) authorize YWCR to release and/or discuss my protected health care information with the following people (valid for 1 yr, unless otherwise specified):

Name:_____ Relationship:_____

Contact#_____

Name:_____ Relationship:_____

Contact#_____

NOTICE OF PRIVACY PRACTICES

The attached Notice of Privacy Practices handout describes how YWCR and/or out-patient service provider's may use and disclose your medical information and how you can obtain a copy. Please review it carefully. Be signing below you acknowledge that you have reviewed the facility Privacy Practices and/or received a copy (available upon request).

_____**Date:**_____

Signature of Patient/Guardian for Release of Info & Privacy Practices

YUKON WOUND CARE AND REHABILITATION

To ALL Wound Care Patients

First & Foremost: Receiving wound care does NOT insure healing.

It is the responsibility of the patient to follow directions and to comply to the guidelines given to you by your Wound Care Specialist.

There are many variables and circumstances out of our control that can delay healing or cause infection that may result in hospitalization or next level of care.

Some of those variables include, but are not limited to:

Lifestyle	Nutrition/Eating Habits	Smoking Habits
Medications	Diabetes (especially A1C's greater than 6)	Circulation Problems
Infection	Shoe Style	Poor-Fitting Shoes
Weight	Edema/Swelling	Wound Placement
Age	Aspirin/Anticoagulants (Blood Thinners)	Pressure
Deformity	Mental Cognition/Communication	Cleanliness

With that said, our Wound Care Specialists strive to heal all wounds in a timely manner, with the latest evidence-based wound healing techniques and dressings that are available.

Patient Signature _____ Date _____

YUKON WOUND CARE AND REHABILITATION
1808 COMMONS CIRCLE, SUITE B
YUKON OK, 73099
(405)265-2255

AUTHORITY TO INTERVIEW, PHOTOGRAPH and/or VIDEOTAPE

Patient Name:_____ **DOB:**_____

Address on file: Yes / No

I authorize photographs, videos, and/or interviews of (circle one):

myself / my dependent / my minor child by Sherri Boos, PT, DPT and/or other said employee of Yukon Wound Care & Rehabilitation (YWCR) for purposes of:

health care treatment ONLY / training, teaching and/or social media use (Facebook, Instagram, etc.)

I hereby release YWCR from any and all responsibility or liability attached hereto.

Signature:_____ **Date:**_____

PATIENT INTAKE

Name:_____ **Age:**_____ **Date:**_____

Primary Care Provider: _____ Next Doctor's Appt:_____

Reason for your Visit:_____

Injury: Yes / No Currently Working: Yes / No Occupation:_____

***** If third party injury, you may be responsible for charges (subject to your Insurance policy limits)**

Testing Done: (please circle) NONE / X-Ray / MRI / CT / Other:_____ Location:_____

Previous Treatments: NONE / Wound Care / Physical Therapy / Chiropractor / Injections / Other:

(Please list)_____

Ongoing Health Problems:_____

Medications:_____

Medication Allergies: Yes / No If yes, please list_____

Special Needs: (circle) NONE / Vision/ Hearing / Speech/ Language / Cultural / Religious / Other

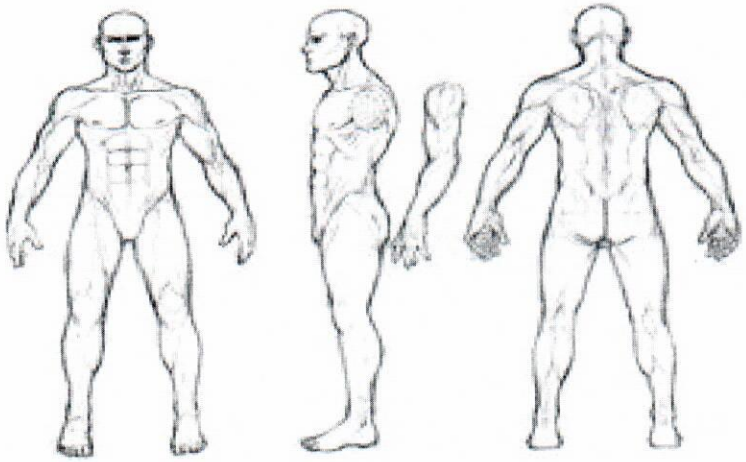
Special Equipment: (circle) NONE / Hearing Aids / Cane / Walker / Wheel Chair / Other:_____

Are you receiving Home Health: Yes / No Home Health Agency:_____

***** If receiving home health, your Insurance cannot be billed and you will be responsible for charges**

What do you expect from your treatment:_____

Please circle affected areas and indicate pain level:



Pain Intensity Scale:

0=no pain / 10=severe pain
(Please circle)

0

1 2 3

4 5 6

7 8 9

10

Provider Notes:_____

_____

_____

_____