Advanced CareTech

Patient Intake Form

Form P001

Patient Information

First Name		Last Name	
Home Phone		Cell Phone	
Street Address		Home Type	☐ Private Residence ☐ SNF/Nursing Home ☐ Residential Care Home ☐ Other _____
City			
State		Zip	
Gender	☐ Male ☐ Female		
Email			

Emergency Contact or Caregiver Information

First Name		Last Name	
Cell Phone		Home Phone	
Email:			
Relationship to Patient			

Insurance Information

SSN	___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___	DOB	___ ___ / ___ ___ / ___ ___ ___ ___
Medicare	☐ Yes ☐ No	Medicare ID	
Primary Insurance		Member ID	
Group #		Insurance Phone	
Secondary Insurance		Member ID	
Group #		Insurance Phone	

Return Forms to: Fax: 888-619-6618 or Email: patients@advancedcaretech.com

Wound #1 Information

Location of Wound #1:

Wound #1 Stage:

- ☐ Stage 1
- ☐ Stage 2
- ☐ Stage 3
- ☐ Stage 4
- ☐ Unstageable

United Needed for Wound #1 (cm^2)

Additional Wound #1 Notes

Wound #2 Information

Location of Wound #1:

Wound #1 Stage:

- ☐ Stage 1
- ☐ Stage 2
- ☐ Stage 3
- ☐ Stage 4
- ☐ Unstageable

United Needed for Wound #1 (cm^2)

Additional Wound #1 Notes

Care Team Information

Provider Name (MD/NP)		Phone	
Facility Point of Contact		Phone	
CareTech Care Coordinator		Phone	

Advanced CareTech

Patient Consent to Treat

Form P002

Patient Information

First Name		Last Name	
SSN		Date of Birth	___ ___ / ___ ___ / ___ ___ ___ ___

1. Consent for Treatment
I voluntarily consent to receive medical care and services provided by Advanced Care Tech, LLC and its affiliated healthcare providers. This includes, but is not limited to:
Outpatient evaluation and treatment, Emergency care as needed, Medications and injections, Laboratory testing and imaging (including x-rays), Medical photography for diagnostic or treatment purposes
All care will be provided under the direction of licensed clinicians and authorized medical staff.

2. Financial Responsibility
I understand that payment is due at the time of service. I agree to be financially responsible for all services rendered by Advanced Care Tech, LLC and its providers.

Acceptable payment methods include cash, Visa, MasterCard, Discover, and American Express.
If I do not have health insurance, I agree to pay the full cost of my visit at the time of service.

If Advanced Care Tech, LLC participates with my insurance provider, I understand that I am responsible for any applicable co-pays, deductibles, co-insurance, and any charges not covered by my policy.

I acknowledge that:

- My insurance contract is between me and my insurance company.
- I must present valid insurance information at every visit.
- If my insurance coverage cannot be verified in advance, I will pay in full at the time of service. A refund will be issued if insurance reimbursement is later received.
- I remain responsible for any balances not paid by my insurance.
- If another individual signs this agreement on my behalf (e.g., spouse or guarantor), that person agrees to be jointly and individually liable for payment. If my account is referred to collections or legal counsel, I agree to pay reasonable attorney's fees, court costs, and collection expenses. Unpaid balances referred to an outside agency will accrue interest at the prevailing legal rate from the date of referral.

3. Insurance Authorization and Coordination
I authorize payment of medical benefits from Medicare, Medicaid, private insurance, or any applicable health plan directly to Advanced Care Tech, LLC for services provided.

I also authorize Advanced Care Tech, LLC to:
Disclose relevant portions of my medical records to insurers, government agencies, worker's compensation programs, or other entities involved in claims processing or healthcare coordination.

Act on my behalf to obtain prior authorizations or pre-certifications when required.

Receive information from my insurer necessary to process claims.

4. Release of Medical Information
I authorize Advanced Care Tech, LLC to share my medical information with other licensed healthcare professionals or facilities involved in my care. This includes providing my records to my Primary Care Physician (PCP) to ensure continuity of care.

5. Notice of Privacy Practices
By signing this agreement, I acknowledge that I have received or been offered a copy of Advanced Care Tech, LLC's Notice of Privacy Practices, which explains how my protected health information may be used or disclosed. I understand that this notice may be updated and that I may request a current version at any time.

6. In-Office Medication Dispensing
For my convenience, Advanced Care Tech, LLC may offer certain prescription medications in-office. I understand:
These are optional and not billed to my insurance or pharmacy benefit plan.
Any medication dispensed is a separate charge in addition to my visit.
I may request a written prescription at no additional cost to use an outside pharmacy of my choice.

7. Personal Valuables
Advanced Care Tech, LLC is not responsible for loss or damage to personal items including, but not limited to, money, jewelry, electronics, documents, eyewear, or other valuables brought into the facility.

Agreement Acknowledgment
By signing below, I confirm that I have read, understand, and agree to all the terms outlined in this agreement. I certify that

I am legally authorized to sign on behalf of myself or the patient named below.

Patient Signature			
Patient Name (Print)			
Provider Signature		Date	___ ___ / ___ ___ / ___ ___ ___ ___

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____Fax (_____)_____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.