Monarch Wound Care

New Patient Intake Form

Patient Information

Patient Name: _____ **Date of Birth:** ___/___/___

Sex: Female Male Other: _____ **Phone Number:** _____

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact Name: _____ **Relationship:** _____

Phone Number: _____ **Date of Birth:** ___/___/___

Primary Care Physician: _____

Primary Care Location: _____

Referring Physician: _____

Referring Physician Location: _____

Home Health Company: _____ **Home Health Nurse:** _____

Insurance Information

Primary Insurance: _____ **Are you the policy holder?:** Yes No

If no, please fill out the following information about the policy holder.

Policy Holder Name: _____

Relationship to Policy Holder: _____ **Date of Birth:** ___/___/___

Secondary Insurance: _____ **Are you the policy holder?:** Yes No

If no, please fill out the following information about the policy holder.

Policy Holder Name: _____

Relationship to Policy Holder: _____ **Date of Birth:** ___/___/___

Initial Assessment

Reason for today's visit: _____

Location of wound and/or swelling: _____

How long have you had this wound and/or swelling?: _____

What is the cause of this wound and/or swelling?: _____

Please list any previous treatments used: _____

Are you experiencing any pain? Yes No

If yes, where is the pain located?: _____

If yes, what is your current pain rating? (0 being no pain - 10 being worst pain)**:** _____

Height: _____ ft _____ in **Weight:** _____ lbs. **Are you experiencing abuse?** Yes No

How did you hear about us?: ☐ Doctor Referral ☐ Google Search ☐ Advertising ☐ Word of Mouth ☐ Family/Friend Referral ☐ Social Media ☐ Other: _____

Family History: Please check all that apply

Condition	Mother	Grandparent	Father	Sibling	Child	No History
Unknown History	☐	☐	☐	☐	☐	
Non-Contributory	☐	☐	☐	☐	☐	
Autoimmune Disease	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Malignant Neoplasm (Skin)	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	

Surgical History	Date

Medical History: Please circle all that apply

Anemia	Gall Stones	Kidney Disease	Respiratory Disease
Arthritis	Glaucoma	Liver Dease	Rheumatoid Arthritis
Asthma	Heart Attack	Low Blood Pressure	Spinal Injury
Cancer	Heart Disease	Mental Illness	Stroke
COPD	High Blood Pressure	Multiple Sclerosis	Thyroid Problems
DVT	HIV/Aids	Osteoporosis	Tuberculosis
Epilepsy	Intestinal Problems	Intestinal Problems	Ulcers
Fibromyalgia	Kidney Stones	Pacemaker	Varicose Veins

Other: _____

Are you currently on a blood thinner or at an increased risk of bleeding? Yes No

Do you have Diabetes? Yes No

If yes, what were your blood sugar levels this morning?: _____

If yes, what was your most recent A1C?: _____

Do you smoke?: Yes No **Stopped:** _____

Have you experienced two or more falls within the past year? Yes No

Have you experienced any fall with injury in the past year? Yes No

Medical Assessment

Do you have any allergies we need to be aware of? Yes No

If yes, please list them below:

Allergy	Reaction

Medications	Strength	Frequency

Monarch Wound Care - Consent to Treat

I hereby give my informed consent for medical treatment and procedures that may be performed by Jacqueline J. Gay PT, DPT, CWS , and your ancillary staff at Monarch Wound Care LLC. This consent includes, but is not limited to, diagnostic tests, medical examinations, surgical procedures, selective procedures to debride non vital tissues, administration of medications, and any other necessary medical interventions deemed appropriate by you or your healthcare team.

I acknowledge that you have explained to me, in terms I understand, the nature of the proposed treatment, its potential benefits, and any associated risks or complications. I have been given the opportunity to ask questions and have received satisfactory answers regarding my concerns. I understand that no guarantee of results or outcomes can be made, and unforeseen circumstances may necessitate the modification of the treatment plan.

I am aware that alternative treatment options may exist and that it is my right to seek a second opinion or explore alternative treatments. However, after considering the available information and discussing my options with you, I have chosen to proceed with the treatment plan as recommended by you.

I understand that the medical records pertaining to my treatment will be kept confidential, except as required by law or in the event of a medical emergency. I authorize the release of my medical records to other healthcare providers involved in my care, as necessary.

I further acknowledge that I am responsible for the payment of medical services rendered and agree to comply with the financial policies of Monarch Wound Care. I understand that any applicable insurance coverage will be billed, but I am ultimately responsible for any outstanding balances.

I have read this consent form in its entirety or have had it read and explained to me, and I understand its contents. I have had an opportunity to ask questions, and my questions have been answered satisfactorily. **By signing below, I acknowledge my consent to treatment.**

Signature: _____

Monarch Wound Care - Consent to Photograph

I hereby give my consent to Monarch Wound Care LLC, its healthcare professionals, and authorized representatives, to take photographs of my wounds for the purpose of monitoring and assessing the progress of my wound healing. I understand that these photographs may be used solely for medical purposes, such as documentation, analysis, and treatment planning.

I acknowledge and understand the following:
1. Purpose of Photographs: The purpose of taking these photographs is to monitor the progression of my wounds and to aid in the appropriate assessment of my wound healing. These photographs will be used for medical purposes only.

2. Confidentiality: I understand that my privacy is important and that Monarch Wound Care LLC will take all necessary measures to protect the confidentiality and security of the photographs taken. The photographs will only be accessed by authorized healthcare professionals directly involved in my care.

3. Potential Uses: The photographs may be used for the purpose of medical education, research, or quality improvement. However, any identifying information, such as my name, will be kept strictly confidential and will not be disclosed without my explicit consent, except as required by law.

4. Voluntary Participation: I acknowledge that the decision to participate in this wound monitoring program is entirely voluntary. I understand that I have the right to refuse or withdraw my consent at any time without affecting my current or future medical treatment.

5. Duration of Consent: This consent shall remain valid until I revoke it in writing or verbally.

6. Revoking Consent: If I decide to revoke my consent, I understand that it may not be possible to continue monitoring my wounds through photographs, and alternative methods of wound assessment may be required.

7. Limitations: I acknowledge that the photographs may not capture all aspects of my wound condition and that they should be used in conjunction with other medical assessments to form a comprehensive evaluation.

By signing below, I confirm that I have read and understood the information provided above. I have had the opportunity to ask questions and have received satisfactory answers. **I willingly consent to the taking of photographs of my wounds for monitoring purposes by Monarch Wound Care LLC.**

Signature: _____

Monarch Wound Care - HIPAA Authorization Form

Patient Name (Print): _____

Date of Birth: ____/____/____ **Phone Number:** _____

Full Address: _____

I hereby authorize the disclosure and use of my protected health information (PHI) as defined by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. **This authorization allows the release of my protected health information to the individuals or organizations listed below**, as necessary, to carry out the purposes specified herein.

Recipient Information (Such as your primary care doctor or referring physician)

Name: _____ **Location:** _____

Name: _____ **Location:** _____

Name: _____ **Location:** _____

Name: _____ **Location:** _____

I understand that once my PHI is disclosed, it may be subject to re-disclosure by the recipient, and the privacy protections provided by HIPAA may no longer apply. I further understand that I have the right to revoke this authorization at any time, except to the extent that action has already been taken based on this authorization. Revocation must be done in writing and sent to the address provided above.

I acknowledge that I have received a copy of this authorization form for my records, upon request.

Signature: _____