Wound Care Experts
Clinical Services | Research | Education

Fort Apache Location: 6050 S Fort Apache Rd. Ste 200B Las Vegas, NV 89148
Eastern Location: 8425 S Eastern Ave Ste A Las Vegas, NV 89123
Phone: (702)803-5534 | Fax: 1(888)977-1206

NEW PATIENT REGISTRATION FORM

CONFIDENTIAL

□ ANNUAL UPDATE
□ INFORMATION CHANGE

PLEASE PRINT

DEMOGRAPHICS

Full Name: _____ Social Security Number: _____ - _____- _____

Date of Birth: _____ Age: _____ Sex: M / F Email: _____

Check one: □ SINGLE □ MARRIED □ DIVORCED □ WIDOWED □ OTHER: _____

Address: _____

(Street) (City/ State/ Zip)

Home Phone: (___ ___) _____ Cell : (___ ___) _____ Work: (___ ___) _____

Employer:_____

INSURANCE INFORMATION

Primary Insurance: _____ Policy Number: _____

Address: _____ Group Number: _____

Guarantor Insurance Information: □Self □ Spouse □ Parent

Guarantor Name (if other than patient) : _____ DOB: _____ SS#: _____

Address: _____ Phone Number _____

Employer Name : _____ Employer Phone: _____

Secondary Insurance: _____ Policy Number: _____

Address: _____ Group Number: _____

Guarantor Insurance Information: □Self □ Spouse □ Parent

Guarantor Name (if other than patient) : _____ DOB: _____ SS#: _____

Address: _____ Phone Number _____

Employer Name : _____ Employer Phone: _____

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? YES ____ NO ____

IF YES, PLEASE NOTIFY RECEPTIONIST

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EMERGENCY CONTACT

Person to Notify in Case of Emergency**:** _____

Phone: _____ Relationship to patient: _____

PHARMACY INFORMATION

Preferred Pharmacy: _____

Major Cross Streets: _____ Phone Number: _____

HOMEHEALTH INFORMATION

Homehealth Agency: _____

Phone Number: _____ Fax Number: _____

Nurse Name: _____ Contact info: _____

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Wound Care Experts. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____ Date: _____

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NEW PATIENT HISTORY

I.IDENTIFYING INFORMATION:

Name: _____ DOB: _____ Date: _____
Occupation: _____ Name of internist or family doctor: _____
List any other physicians or health care providers you see:_____

II. WOUND HISTORY

Wound Location: _____ Wound Size: _____
Wound Etiology/Cause: _____
_____
How long has the wound been present? _____
Previous wound treatments _____

III. MEDICAL HISTORY □ None

List any medical problems that you have.

_____
_____
_____

Check if you have or have you ever had:

□ Alcohol abuse	□ Anesthetic reaction	□ Bleeding disorder
□ Asthma	□ Anemia	□ Chronic lung condition
□ Blood clots	□ Drug and substance abuse	□ Depression/anxiety
□ Diabetes	□ Heart disease	□ High blood pressure
□ High cholesterol	□ Hepatitis/Jaundice	□ Cancer (Type)
□ Irritable bowel syndrome	□ Kidney stones	□ Hypothyroidism
□ Seizure disorder	□ Stroke	□ Tuberculosis
□ Stomach ulcers	□ Mitral valve prolapse	□ Rheumatic fever
□ Transfusion reaction	□ Eating disorder	□ Lupus/autoimmune

IV. ALLERGIES AND MEDICATIONS

Are you allergic to any of the following? If yes, what is the effect?

□ Aspirin	□ Local Anesthetics	□ Acrylic	□ Metal
□ Penicillin	□ Latex	□ Sulfa Drugs	□ Codeine

□ Other: _____

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List all medications that you take with the dose and timing (including all non-prescription medications that you take regularly including vitamins, herbs and anti-inflammatory medications.): □ None

Drug	Dose	Frequency	Reason for medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

V. SURGICAL HISTORY

List all surgeries you have had

Description:	Date:	Description:	Date:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

VI. SOCIAL HISTORY:

Do you Smoke? □Yes □ No Amount/ day : _____ How many years: _____

If you quit smoking, when did you stop?: _____

Do you Drink? □ Daily □ Weekly □ Occasionally □ Quit since : _____

Have you used marijuana or other drugs in the last 5 years? □Yes □ No Type: _____

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AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth : _____

I hereby authorize _____ to disclose, release, or exchange protected health information (PHI) during the term of this Authorization to the recipient(s) that I have identified below.

Recipient Information: I authorize my health care information to be released to the following recipient(s):
Name:

_____

Address:

_____

Purpose: I authorize the release of my health information for the following specific purpose:

_____

Information to be disclosed: I authorize the release of the following health information:

□ All of my health information that the provider ha in his or her possession.

□ Only the following records or types of health information: _____

This is a
□ One-Time Disclosure
□ Continuous Disclosure for 12 months beginning: _____

I understand that I may revoke this authorization in writing at any time, except to the extent that the release has been made prior to my revocation in reliance on this authorization and that such release shall not constitute a breach of my right to confidentiality, unless I otherwise revoke this authorization in writing, it shall expire on the following date, event, or condition. _____
I hereby release Wound Care Experts and the Clinician from any liability in the event my data is used as provided herein.

Patient Name: _____ Date: _____

Signature: _____

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DEBRIDEMENT CONSENT

Patient Name: _____ Date of Birth: _____

Facility/Hospital: Wound Care Experts

The risk and benefits including, but not limited to: bleeding and infection, potential scarring, possible damage to blood vessels or surrounding areas such as organs and nerves, allergic reactions to topical and injected local anesthetics or skin preparation solutions, excessive bleeding, removal of healthy tissue, infection, ongoing pain and inflammation, and failure to heal.

The patient acknowledges that he/she acknowledges that the provider has explained the procedure and its risk and benefits.

Patient hereby consent Dr. Wahab to perform the procedure, wound debridement and application of cellular tissue product.

_____ _____
Patient Signature Date

_____ _____
Provider Signature Date

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FINANCIAL POLICY

Welcome to *Dr. Wahab's office*. The following outlines the patient financial responsibility policy.
Payment for services provided by *Naz Wahab, MD* is required at the time of services unless prior arrangements have been made. **Co-pays, co-insurance, deductibles, and/or non-covered services are due at the time of service, no exceptions.** If we are contracted with your insurance company, we will bill your insurance company as a courtesy to you. Understand that it is ultimately your responsibility as the patient to know your insurance coverage. We encourage every patient to know their medical benefits, if you need further clarification contact your insurance company directly. Although, Dr. Wahab does contact your insurance company monthly for benefits, please be aware that benefits quoted to Dr. Wahab is not a guarantee of benefits and/or payment. Co-Insurance and allowable information given to Dr. Wahab is an estimate and further payment may be required after your claim has been paid. Exact payment is not determined until your claim is process by your insurance company.

Initials _____

Please understand that as your medical office we are not obligated to send out statements. We do this as a courtesy to the patient. As a patient you should receive an EOB from your insurance company that will indicate what the insurance company paid on a specific claim and what they did not pay which in turn would be owed to the medical office. After 90 days, if we haven't heard back from your insurance company on any insurance claim that has not been paid by the insurance company, we will provide you with a HCFA and proof of timely filing to send to your insurance company to help you get the claim paid. The charges will be turned over to you as the patient.

Initials_____

All medications and medical supplies provided by any of the physicians should be completely paid for at the time of service. Services provided by outside laboratories such as blood works and/or biopsies will be **billed directly to you by the outside laboratory**. If you need to be referred to a specific laboratory or cytology lab, it is your responsibility to communicate this information to the physician.

Initials _____

If *Naz Wahab, MD* is **not contracted** with your insurance company and you need a medical service, we will provide you with our cash 20% discount to help you estimate the cost of your medical services. A financial agreement form will be completed which should include the cost of the service. Financial arrangements can be discussed in advance so that a specific payment plan can be arranged, if necessary. All fees are required to be paid in full prior to service. You can use your out of network benefits if they are available if you choose.

Initials _____

Our statements show in detail charges incurred during the statement period and the amount due. Any uncollected fees are **payable within 15 days** of receiving the statement. You are responsible for complete payment of any charges that you incur whether covered by your insurance or not covered by your insurance. A finance charge of **1.5%** per month or **18%** annually will be incurred 30 days following the date of the services were provided. If your account becomes delinquent or referred to a collection agency, you will be responsible for the costs of collection and/or legal fees. All accounts that are 90 days past due will automatically be assigned to a collection

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agency, regardless of insurance coverage. Accounts assigned to collections will include a **35%** collection and processing fee.

Initials _____

There will be a **$50.00 cancellation fee** for all appointments not cancelled within 48 hours of the appointment. A fee of **$100.00** for all in-office procedural appointments not cancelled within 48 hours of appointment. A **$100.00** fee will be charges for all re-deposited, returned checks or stop payments.

Initials _____

I authorize Dr. Wahab to release to my insurance carrier and its agents any information needed to determine the benefits payable under their coverage. I further authorize my insurance company and its carriers to disclose any information requested regarding claims for medical benefits to Dr. Wahab. A copy of this authorization may be used in place of the original.

Initials _____

I request that payment of authorized medical benefits be made on my behalf to Dr. Wahab for services furnished to me, any physician covering for the care of her patients, or her staff unless I have paid for the services and will be billing the insurance company directly.

Initials _____

I understand that the office of Dr. Wahab will take cash, check and credit card as forms of payment. I understand I will be providing a credit card on file to cover any expenses not covered by my insurance and will only be used to cover my balance under $100.00 including NO SHOW FEES

Initials _____

Your signature below indicates that you understand and agree to this financial policy. You also are acknowledging that you have read and/or received a copy of this practices ***NOTICE OF PRIVACY PRACTICES.***

Signature of Patient: _____ Date: _____

Signature of Parent/Legal Guardian: _____

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CONSENT AND PERMANENT RELEASE OF RIGHTS TO ANONYMOUS DATA

I, _____, ("Individual") hereby irrevocably grant Wound Care Experts, and its subsidiaries, affiliates, and their employees and agents (collectively Wound Care Experts) and the undersigned Clinician the right and permission to reproduce or otherwise use my quotations, audio or video recordings and/ or photographic images or likenesses (collectively, the "Data") world- wide in a manner that does not provide or disclose my personally identifying information (such as my name, hospital identification number, or images or likenesses of my face) for (i) Clinician's and Wound Care Experts' health education purposes, including in connection with educational teaching and any research papers or case studies which the Clinician may prepare or which Wound Care Experts may prepare or have prepared, and (ii) Wound Care Experts' commercial and other for – profit purposes including marketing. I understand that my Data may be used in conjunction with other photographs, drawings, videotape, images, sound recordings or other forms of illustration. I understand that the Clinician may provide his/her research findings or case studies, including my Data, to one or more institutions (including Wound Care Experts) which may publish (including electronically) the research findings, case studies and/ or Data, and, as a result, there is a chance that my Data may be seen or accessed by the general public worldwide. I hereby relinquish all rights, title and interest, in and to any material that may be created or used in connection with my Data. I hereby waive any and all rights to payment or compensation, now and in the future, from Wound Care Experts and/ or the Clinician for use of my Data as provided herein or for any material that may be created or used in connection with my Data. I hereby release and hold harmless Wound Care Experts and the Clinician from liability in the event my Data is used as provided herein.

This authorization is ongoing and without limitations or restriction to time.

CLINICIAN	**INDIVIDUAL**
Signature of the Clinician	Signature of Individual (or parent or legal guardian if person is under the age of 18)
Naz Wahab, MD Print Name	Print Name
6050 S Fort Apache Rd. Ste 200B Address of Institution	Address
Las Vegas, NV 89148 Address of Institution (continued)	Address (continued)
702-803-5534 Telephone/ Email Address	Telephone/Email Address
Date	Date