WOUND CENTER REGISTRATION FORM
REX HEALTHCARE

PATIENT IDENTIFICATION

Rex Healthcare will compare your Legal Name to your Legal ID

Patient's Legal Name (Last, First, Middle) ______________________________

Sex__________ Last 4 digits of Social Security # _________ Birth date ______________________

PATIENT INFORMATION

Race ________________________ Ethnicity _____________________ Marital Status _______________

Mailing Address ____

City________________________ State________________ Zip Code ____________________

Home Phone #__________________ Alternate Phone ______________________________

Email Address ____

PATIENT'S EMPLOYMENT INFORMATION

Employment Status_________________ Retirement Date (if applicable)___________________

Employer's Name ____

Phone ___________________________________ Ext. ___________________________

GUARANTOR INFORMATION (Person Financially Responsible)

Name of Guarantor _______________________Relation to Patient ___________________

Social Security # _______________ Sex_________ Birthdate ________________________

Mailing Address ____

City ____________________________ State_____________ Zip Code __________________

Home Phone # ______________________________ Alternate Phone#___________________

Employer's Name ____

Email Address____

EMERGENCY CONTACT

Name of Emergency Contact _____________________ Relation to Patient _______________

Mailing Address ____

City ______________________________ State _______________ Zip Code _____________

Home Phone# _________________________ Cell phone/Alt Phone# ___________________

WOUND CENTER REGISTRATION FORM
REX HEALTHCARE

MEDICAL INFORMATION

Referring Physician/Source ______________________________

Personal/Primary Physician ______________________________

HOSPICE INFORMATION

Are you enrolled in a Hospice Program? ________________

If yes, is this service related to your hospice diagnosis? __________

If yes, which Hospice agency are you enrolled with? ______________________

If yes, what is the name of Hospice Assigned Physician: ______________________

ACCIDENT INFORMATION (Complete this section ONLY if your condition is accident related)

Type of Accident (Auto, Crime, Work, Other) ______________________________

Accident date and time ___/___/________:______

Place of accident and county ______________________________

State where the accident occurred ______________________________

Brief Description of Accident ______________________________

WOUND CENTER REGISTRATION FORM
REX HEALTHCARE

ALLERGIES

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

MEDICATIONS (Please list all prescriptions, over the counter medications, herbs & vitamins)

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

PHARMACY:______________________________

FAMILY MEDICAL HISTORY

Relationship	Alive/ Deceased	Alcohol Abuse	Arthritis	Asthma	Cancer	COPD	Depression	Diabetes	Drug Abuse	Early Death	Heart Disease	Hyperlipidema	Hypertension	Kidney Disease	Mental Illness	Mental Retardation	Miscarriages	COPD	Depression
Mother																			
Father																			

Relationship	Alive/ Deceased	Hearing Loss	Vision Loss	Learning Disability	Birth Defects	Lupus	Aneurysm	Angina	Clotting Disorder	Liver Disease	Ulcers	GER Disease	Seizures	Thyroid Disease	Glaucoma	Colon Cancer	Prostate Cancer	Stroke	
Mother																			
Father																			

FEMALES

☐ Last Menstrual Period______________ ☐ Postpartum ☐ Post Menopause

☐ Pregnant ______ # of Weeks ☐ Breastfeeding

SOCIAL HISTORY

Tobacco Use No ___ Yes ___ Quantity ____
Alcohol Use No___ Yes ___
Drug Use No ___ Yes ____

DOMESTIC ABUSE

Is abuse, violence, or sexual assault a problem for you in any way?
No _____ Yes ____

Does your partner/caregiver threaten you in anyway?
No _____ Yes ____

ASSISTIVE DEVICES

☐ Cane ☐ Wheelchair ☐ Tubes ___ ☐ Stairs at Home

☐ Walker ☐ Splints/Braces ☐ Bedside Commode ☐ Railings Available

☐ Oxygen ☐ Crutches ☐ Prosthesis____ ☐ Ramp Available

☐ Provider of Equipment _____________

WOUND CENTER REGISTRATION FORM
REX HEALTHCARE

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?

		CONSTITUTIONAL			EYES			ENDOCRINE			ALLERGIES/IMMUN
Y	N	Activity change	Y	N	Eye discharge	Y	N	Cold intolerance	Y	N	Seasonal allergies
Y	N	Appetite change	Y	N	Eye itching	Y	N	Heat intolerance	Y	N	Food allergies
Y	N	Chills	Y	N	Eye pain	Y	N	Excessive thirst	Y	N	Immunocompromised
Y	N	Sweating	Y	N	Eye redness	Y	N	Excessive hunger			**NEUROLOGICAL**
Y	N	Fatigue	Y	N	Bright light intolerant	Y	N	Excessive urination	Y	N	Dizziness
Y	N	Fever	Y	N	Visual disturbance			**GYNECOLOGICAL**	Y	N	Facial asymmetry
Y	N	Weight change			**RESPIRATORY**	Y	N	Diff. Urinating	Y	N	Headaches
		EARS, NOSE, THROAT	Y	N	Apnea	Y	N	Painful intercourse	Y	N	Light-headedness
Y	N	Facial swelling	Y	N	Chest tightness	Y	N	Burning urination	Y	N	Numbness
Y	N	Neck pain	Y	N	Choking	Y	N	Los of urine incont	Y	N	Seizures
Y	N	Neck stiffness	Y	N	cough	Y	N	Flank pain	Y	N	Speech difficulties
Y	N	Ear discharge	Y	N	Shortness of breath	Y	N	Urinary frequency	Y	N	Fainting
Y	N	Hearing loss	Y	N	Stridor	Y	N	Genital sores	Y	N	Tremors
Y	N	Ear pain	Y	N	Wheezing	Y	N	Blood in urine	Y	N	Weakness
Y	N	Ringing ears			**CARDIOVASC.**	Y	N	Menstrual problems			**HEMATOLOGICAL**
Y	N	Nose bleed	Y	N	Chest pain	Y	N	Pelvic pain	Y	N	Swollen Glands
Y	N	Congestion	Y	N	Leg swelling	Y	N	Urinary urgency	Y	N	Bruise/bleed easy
Y	N	Runny nose	Y	N	Palpitations	Y	N	Decreased urine			**PSYCHIATRIC**
Y	N	Postnasal drip			**Gastrointestinal**	Y	N	Vaginal bleeding	Y	N	Agitation
Y	N	Sneezing	Y	N	Distention	Y	N	Vaginal discharge	Y	N	Behavioral problem
Y	N	Sinus pressure	Y	N	Abdominal pain	Y	N	Vaginal pain	Y	N	Confusion
Y	N	Dental problems	Y	N	Anal bleeding			**MUSCULOSKELETAL**	Y	N	Issue concentrating
Y	N	Drooling	Y	N	Blood in stool	Y	N	Joint aches	Y	N	Depression
Y	N	Mouth sores	Y	N	Constipation	Y	N	Back pain	Y	N	Hallucinations
Y	N	Sore throat	Y	N	Diarrhea	Y	N	Gait problems	Y	N	Hyperactivity
Y	N	Trouble swallowing	Y	N	Nausea	Y	N	Muscle aches	Y	N	Nervous/anxious
Y	N	Voice changes	Y	N	Rectal pain			**SKIN**	Y	N	Self-injury
			Y	N	Vomiting	Y	N	Color changes	Y	N	Sleep disturbance
						Y	N	Pallor	Y	N	Suicidal ideation
						Y	N	Rash			
						Y	N	Wound			

LEARN BEST BY (Please mark all areas that apply)

☐ Reading ☐ Not Able to Read ☐ Verbal ☐ Visual ☐ Video ☐ Demonstration

WOUND CENTER REGISTRATION FORM
REX HEALTHCARE

Patient Medical History								
Anemia	Yes	No	Diabetes	Yes	No	Myocardial Infarction	Yes	No
Anxiety	Yes	No	Emphysema	Yes	No	Nerve / Muscle Disease	Yes	No
Arthritis	Yes	No	GERD	Yes	No	Osteoporosis	Yes	No
Asthma	Yes	No	Glaucoma	Yes	No	Seizures	Yes	No
Cancer	Yes	No	Heart Murmur	Yes	No	Sickle Cell Anemia	Yes	No
Cataracts	Yes	No	Hepatitis	Yes	No	Stroke	Yes	No
CHF (Congestive Heart Failure)	Yes	No	HIV/AIDS	Yes	No	Substance Abuse	Yes	No
Clotting Disorder	Yes	No	Hypertension	Yes	No	Thyroid Disease	Yes	No
COPD	Yes	No	Kidney Disease	Yes	No	Tuberculosis	Yes	No
Depression	Yes	No	Meningitis	Yes	No	Ulcers (GI)	Yes	No

Barriers To Care								
Caregiver Burden	Yes	No	Homeless	Yes	No	Mental / Behavioral Problem	Yes	No
Cognitive Impairment	Yes	No	Impaired Mobility	Yes	No	Non-English Speaking	Yes	No
Falls Risk	Yes	No	Inadequate Social / Family Support	Yes	No	Terminal Illness / Hospice	Yes	No
Financial Difficulty	Yes	No	Ineffective Family Coping	Yes	No	Transportation Issues	Yes	No
Frail Elderly	Yes	No	Low Literacy	Yes	No	Visual Impairment	Yes	No
Hearing Impairment/Loss	Yes	No						

Surgical History								
Appendectomy	Yes	No	C-Section	Yes	No	Prostate Surgery	Yes	No
Brain Surgery	Yes	No	Eye Surgery	Yes	No	Small Intestine Surgery	Yes	No
Breast Surgery	Yes	No	Fracture Surgery	Yes	No	Spine Surgery	Yes	No
CABG (Heart Bypass)	Yes	No	Hernia Repair	Yes	No	Tubal Ligation	Yes	No
Cholecystectomy (Gall Bladder Surgery)	Yes	No	Hysterectomy	Yes	No	Valve Replacement	Yes	No
Colon Surgery	Yes	No	Joint Replacement	Yes	No	Vasectomy	Yes	No
Cosmetic Surgery	Yes	No						

Person Completing Form ______________________ Relationship (If other than patient) __________

ADVANCE DIRECTIVE (To be completed by Hospital staff)

Does the patient have an advance directive (Living Will, Healthcare POA)? ☐ Yes ☐ No

☐ Copy of AD must be available now to be placed in the medical record. If no copy available, do not check "Yes"

☐ Information Provided ☐ Information Decline ☐ Cannot Assess

Decision maker in the event of an emergency__________________ Phone #_______________

UNC HEALTH CARE

Patient Name____________________
Date of Birth____________________

Limited Release of Information to Family/Friends for Physician Clinics
HIM# 1315s

I give my permission to my physician practice that is part of the UNC Health Care System to share certain personal health information about me with the individuals listed below. These individuals will only be given information about me that is related to their involvement in my care or payment for my care.[1] I understand that I am not required to complete this form in order to obtain health care.

Name: ______________________________ Phone Number: ______________________________
Relationship: ______________________ Talk to this person about (*check each box that applies*):

☐ Any non-sensitive[2] information regarding my health care or payment for my health care.

OR

☐ Only these things:

	My appointments – scheduling & reminders		My test results
	My after visit summary (AVS)		My bills
	Other:		

Name: ______________________________ Phone Number: ______________________________
Relationship: ______________________ Talk to this person about (*check each box that applies*):

☐ Any non-sensitive[2] information regarding my health care or payment for my health care.

OR

☐ Only these things:

	My appointments – scheduling & reminders		My test results
	My after visit summary (AVS)		My bills
	Other:		

If I change my mind about the people or the contact information I have listed in this form, I will complete a new form with such changes.

____ DATE: ______________ TIME: __________
PATIENT SIGNATURE (or Authorized Representative)

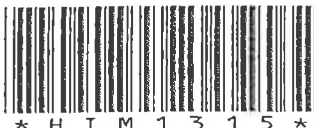
PRINTED NAME & RELATIONSHIP (if not patient): ______________________________

[1] This form is not a substitute for a health care power of attorney or other formal designation of an individual authorized to make health care decisions for you if you are not able. If an individual listed above is your guardian or agent (under a power of attorney), or is otherwise authorized by law to act on your behalf, your health care provider may share as much of your personal health information with that person as the law permits.

This form is not a substitute for a valid HIPAA compliant written authorization when it is required to release copies of medical and billing records or information.

[2] Non-sensitive information excludes mental health, alcohol and substance abuse, HIV and other communicable diseases, and genetic testing. **This form is not considered sufficient authorization to release sensitive information.**

Chart Location: Consents



HDF5338 06/09/17

UNC REX
HEALTHCARE

Rex Wound Healing Center of Raleigh, a department of Rex Hospital

Dear Patient:

The **Rex Wound Healing Center of Raleigh** is an outpatient practice location of **Rex Hospital**. The billing process in this clinic is different from the billing process in a private physician's office. You (or your insurance provider) will receive billing statements from two separate billing offices, one statement from the North Carolina Surgery, and another statement from **Rex Hospital**. The **North Carolina Surgery**, will bill you for medical provider services such as those of a medical doctor, nurse practitioner or physician assistant. Rex Hospital bills you for the clinic facility, drugs and drug administration, and any tests you receive during your visit. Billing statements will be sent to you from the **North Carolina Surgery** and **Rex Hospital** at different times.

If we know in advance that a medical service is not covered by your insurance company, or if you do not have insurance, we will ask you to sign either an Advanced Beneficiary Form (ABN form) for Medicare or a Waiver (for other insurance companies) for specific medical charges. The ABN form or Waiver states that you agree to be held personally responsible for any charges listed on the form not covered by your insurance company or if you do not have insurance. Additionally, you may be responsible for a coinsurance and/or deductible for bills received from both the **North Carolina Surgery** and **Rex Hospital**.

- Since we do not know the exact type and extent of services that you may need, we are unable to provide you with an estimate of your liability. However, the typical charge incurred by a beneficiary based on all visits to this department or facility normally ranges between **$10 and $2500**.

The actual amount of your coinsurance liability to the hospital may be different from any estimate that is provided above. Actual coinsurance liability will be based on the services that you may receive and also subject to final determination by the Medicare program or your other policy limitations and insurance carrier.

If you are enrolled in a state medical assistance program such as Medicaid, your coinsurance liability may be reduced or eliminated by law.

Please call the following numbers for billing related questions. If you have questions regarding your physician bill, call the **North Carolina Surgery at 1-800-594-8624**. If you have questions regarding your **Rex Hospital bill, call 1-866-687-7674.**

We are committed to excellence in patient care. You will receive the best medical care possible. We look forward to providing services to you and your family.

Signature____**Date**______________________

NORTH CAROLINA SURGERY
UNC HEALTH CARE

Rex Wound Healing Centers Patient Responsibilities

Medical care requires an ongoing collaborative effort between patients, physicians, and Rex Wound Healing Center staff members. Physicians and staff members have the responsibility to provide health care services for each patient to the best of our ability. This partnership also requires that the patient has certain responsibilities in their health care to ensure that their wound healing needs are adequately met.

1. Good Communication. Patients have the responsibility to communicate openly and participate in decisions regarding their treatment recommendations.

2. **Medical History**. Patients have the responsibility to provide any pertinent medical records (including a medication list) that will assist the physician with their treatment plan.

3. **Health Status**. Patients have the responsibility to request information or clarification regarding their prescribed treatment plan. You will receive a printed copy of your wound care instructions at checkout from your appointment for you to refer to at home when you are performing your wound care.

4. **Compliance with Wound Healing Center treatment plan.** Patients have the responsibility to follow the prescribed treatment plan for wound healing. **This includes making every effort to control blood sugar levels, making an effort to quit smoking, taking medications as prescribed, offloading wounds as directed, taking dietary supplements and vitamins as directed, completing wound care at home as directed and keeping wound healing center appointments.** Patients also have the responsibility to inform the physician or medical staff when they are not following the treatment plan so that a new plan can be developed for the patient's continued wound healing success. The Wound Healing Center can only provide **limited** wound care supplies (i.e. dressings and ointments) until home health services begin or you receive wound care supplies from the medical supply company.

5**. Financial obligation**. Patients have the responsibility to meet their financial obligations by paying co-pays at the time of service and paying for any non-covered services at the time of service.

6. **Behavior**. Rex Wound Healing Center physicians and staff want each patient to have an excellent wound healing experience. We will treat all patients with respect and courtesy. Patients have a responsibility to take an active part in their healthcare, but this will need to be done by conducting themselves in a respectful and courteous manner toward physicians or medical staff members. **Some examples of behavior that will not be tolerated include any type of yelling or profanity toward any caregiver (this includes home health staff), threatening or abusive comments, or purposely disconnecting a phone call while a physician or staff member is trying to assist you**. Any of these behaviors may result in a dismissal from the Wound Healing Center. **We ask that patients and care givers please refrain from any cell phone use**, so that we can have your undivided attention during clinic appointments. We request that **only 1 person** (family member or care giver) accompany you to the treatment room at your appointment.

7. **Keeping appointments**. It is very important for patients to keep their scheduled appointments. We ask for a 24 hour notice if you need to cancel an appointment. We ask that you arrive 30 minutes prior to your scheduled appointment time if this is your first visit to the Wound Healing Center. Please arrive 15 minutes ahead of your scheduled appointment time if you are an established patient. **If you arrive more than 15 minutes late for your appointment you may need to be rescheduled. This will be at the discretion of the doctor according to the clinic schedule for the day. More than three no shows, cancellations, or greater than 15 minutes late arrivals may result in dismissal from the Wound Healing Center.**

We understand your time is valuable. Every effort will be made to see you at your scheduled appointment time, however, some patients may require more time for treatment. If you wait more than 15 minutes past your scheduled appointment time you may request to reschedule your appointment.

We look forward to partnering with you to meet your wound healing goals.

I have read and understand the above responsibilities.

Signature__________________________________ Date________________________

Print Name_________________________________DOB________________________