St. Mary Center for Wound Healing and Hyperbaric Medicine
New Patient Packet

Thank you for choosing St. Mary Center Wound Healing and Hyperbaric Medicine and St. Mary Medical Center to help to treat your wound.

Our center is located at 1 Cornerstone Drive, Suite 500, Langhorne, PA 19047. If you need further directions, please do not hesitate to contact us at 215.710.HEAL (4325).

The following items should be brought in with you:

1. A completed patient history. Please arrive 15 minutes early to complete any other necessary paperwork.
2. A list of all your current medications and allergies as well as your pharmacy name and phone number.
3. A prescription from your referring or primary physician for evaluation and treatment of your wound.
4. Your insurance cards and photo ID for copying.

If you need referrals, please request two of them. One for St. Mary Medical Center and one for the physician who will be treating you. Fax: 215.702.1579.

Knowing your insurance benefits is your responsibility. Prior to your appointment, please contact the member phone number listed on the back of your insurance card to verify your deductible and co-pays for regular wound care visits and for procedures such as debridements, etc performed in an outpatient setting. Copays/deductibles for the hospital will be assessed at your visit based upon the care delivered and will be collected following your visit/procedure. A member of our team will review your financial obligation with you following your initial visit. You will receive separate bills from the physician and the hospital for your care.

We look forward to meeting you.

Sincerely,

The team at St. Mary Center for Wound Healing and Hyperbaric Medicine

Wound Care Patient Billing Information

Our Wound Healing & Hyperbaric Medicine Center (WHHMC) serves as a hospital outpatient clinic where doctors and nurses treat people with wounds that they may have had for a long time. **Visits to the Center will result in charges from both the hospital and doctor.**

Many times, these visits will only result in a charge for a procedure such as a wound debridement, but sometimes they may also include a clinic visit. Sometimes, there may be charges for hyperbaric oxygen therapy, laboratory tests, ex-rays, and other services that may be performed in the hospital.

We understand this can be a confusing time and have outlined various ways the payment of the services provided to you can be handled. If you have questions about the process, please feel comfortable discussing this with one of the WHHMC staff members.

The Hospital
When the hospital bills your insurance company(s) for the services you received at the WHHMC, the bill contains charges for what is called the **technical component**. This fee may also be listed on your bill as the clinic fee or some other hospital-specific term. This fee includes the use of the WHHMC's staff, room, equipment, etc. as well as any supplies that were used. You may also see laboratory charges, radiology (x-ray) charges, and other additional services if they were provided during that billing period. Some hospitals may bill for these additional services on a separate bill.

The Doctor
Each doctor that sees and treats you will bill separately for their services. Most of the time, this bill will come from his or her office, but sometimes hospitals may bill for the doctor's charges. These charges will be for the professional component and includes only the services the doctor provided.

The doctors at WHHMC are specially trained in provided wound care and the insurance companies know to pay for only one set of services by the codes used on the bill sent to them. They will pay a portion of the service to the hospital and a portion to the doctor. You will not be billed twice for the same service even though the description of the services may be the same.

Other Doctors
There are different specialists who may be called in on your case, depending on the difficulty of your wounds, and they may submit a bill as well. These may be from the pathologist for the professional component of the laboratory tests performed, or the radiologist for the services rendered when x-rays were performed, etc.

These billing practices are consistent within all departments of the hospital as well as within the hospital industry. In addition, these billing procedures are frequently audited by Medicare/ Medicaid and accepted as standard practice.

If your primary insurance is Medicare:
The hospital will Medicare and may send you a courtesy copy of your itemized bill upon request. Medicare will notify you when they have paid their portion of your hospital bill. If you have a secondary insurance, the hospital will also send them a bill for their portion and that company will contact you to let you know when and what they paid to the hospital. After payments are received by either your primary and/or secondary insurance, any outstanding balances will be your responsibility. This payment is necessary since the services were performed at a hospital outpatient department. If you are responsible for the co-payment balance, your payment per individual HBO treatment, procedure or other service may range from $21 – $98 (co-payments may range $270 – $314 if either a bone debridement or cellular or tissue-based product procedure performed).

If your primary insurance is Medicaid:
The hospital will bill Medicaid and may send you a courtesy copy of your itemized bill upon request. Medicaid traditional or Managed Care may require a co-payment that is due at the time of service. The hospital should be able to inform you of your co-payment.

If your primary insurance is an Individual/Group PPO or HMO:
The hospital will bill your insurance company. You will be responsible for any deductible and/or co-payment amounts. Payment for these items may be expected at the time of service. Insurance verification will help us to identify your appropriate deductible and co-payment amounts. Copays and deductibles can vary significantly among plans and patients and should contact their plan if they have questions about these amounts.

If you do not have insurance coverage:
Many hospitals require a payment (either in full or partial) at the time of the visit. If you are unable to pay, many hospitals will work with you to determine if you qualify for some type of assistance or will allow you to set up a payment plan. The Center can refer you to the hospital's business office as needed. You cannot be seen in the Center until these arrangements are completed.

If you have questions regarding your bills/statements:
Please call the hospital's business office. Hours of operation are usually between 9:00 a.m. – 4:30 p.m., Monday – Friday. If your question is regarding the provider services, you will need to contact the provider's office.

10-16011

Patient Consent Form for Release of Information

Referring Physician

Name: _____

Address: _____

_____

Specialty: _____

Phone: _____

Patient Initials: _____

Referring Physician

Name: _____

Address: _____

_____

Specialty: _____

Phone: _____

Patient Initials: _____

Referring Physician

Name: _____

Address: _____

_____

Specialty: _____

Phone: _____

Patient Initials: _____

Referring Physician

Name: _____

Address: _____

_____

Specialty: _____

Phone: _____

Patient Initials: _____

I,_____, have placed my initials under the physician/agency who are to receive periodic reports of my condition and progress.

_____

Patient Initials Patient Signature Date

Patient History

Patient Label

General Information **Date:** _____

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____ Age: _____ Sex: _____

Email: _____

Social History

Do you live alone: ☐ Yes ☐ No

Do you drive: ☐ Yes ☐ No

Employed: ☐ Yes ☐ No

What is the highest school grade you completed? ☐ 1 – 6 ☐ 7 – 9 ☐ 10 ☐ 11 ☐ 12 ☐ Some college ☐ College graduate

Marital Status: ☐ Separated ☐ Divorced ☐ Married ☐ Single ☐ Widowed Spouse Name: _____

Do you smoke: ☐ Yes ☐ No If Yes, for how many years: _____ How many packs per day: _____ If quit, when: _____

Do you drink alcohol: ☐ Yes ☐ No History ☐ Prior History ☐ Current History _____ Type: _____

Do you use recreational drugs: ☐ Yes ☐ No If Yes, amount: _____ Type: _____

Caffeine Use: ☐ Yes ☐ No If Yes, for how many years: _____ How many cups per day: _____

Financial Concerns: ☐ Yes ☐ No

Food/Clothing/Shelter Needs: ☐ Yes ☐ No

Support System Intact: ☐ Yes ☐ No

Transportation Concerns: ☐ Yes ☐ No

How will you travel to center: ☐ Car ☐ Ambulance ☐ Ambulette ☐ Public ☐ Other: _____

Emergency Contact Information

Name: _____ Primary Phone: _____

Relationship: _____ Secondary Phone: _____

What provider referred you to the Wound Care Center®?

Name: _____ Specialty: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Who is your primary provider?

Name: _____ Specialty: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

If your provider did not refer you, how did you hear about our Wound Care Center®?

☐ Self-referral ☐ Recently discharged from another hospital ☐ Recently discharged from this hospital ☐ Advertising

☐ Friend/Family ☐ Former patient ☐ Home Health ☐ Extended Care Facility (SNF, LTAC, Nursing Home)

Please provide contact information (if applicable):

Home Health Agency: _____ Phone: _____

Nursing Home/Skilled Nursing Facility: _____ Phone: _____

Pharmacy: _____ Phone: _____

Do you have any of the following?

Advance Directive: ☐ Yes* ☐ No	Living Will: ☐ Yes* ☐ No	Medical Power of Attorney: ☐ Yes* ☐ No	Do Not Resuscitate: ☐ Yes* ☐ No

*Copy required for chart. Requested by: _____ Date: _____ Time: _____

☐ Copy provided. Signature: _____ Date: _____ Time: _____

Name of Person Completing Form: _____ **Relationship to Patient:** _____

Signature: _____ **Date:** _____ **Time:** _____

Reviewed By: _____ **Date:** _____ **Time:** _____

Patient History–Continued

Patient Label

Wound History

Wound location: _____

When did you first notice the wound? _____ Has it ever healed and then re-opened? ☐Yes ☐No

How did your wound start? ☐Bite ☐Blister ☐Bruise ☐Bump ☐Chemical Burn ☐Footwear ☐Frostbite ☐Not Known ☐Gradually Appeared ☐Other Lesion ☐Pimple ☐Pressure ☐Radiation Burn ☐Surgical ☐Thermal Burn ☐Trauma

How have you been treating your wound until now? _____

Have you had any lab work done in the past month? ☐Yes ☐No If Yes, who ordered? _____

Have you ever had bacteria that resisted antibiotics)? ☐Yes ☐No If Yes, Date: _____

Have you ever had a bone infection? ☐Yes ☐No If Yes, Date: _____

Have you had any tests for blood flow in your legs ? ☐Yes ☐No If Yes, Date: _____

If Yes, where was it done: _____ Who ordered? _____

Have you had any other problems with your wound? ☐Infection ☐Swelling ☐Other: _____

Patient's Medical History
(Please check Yes or No for each item)

	Yes	No		Yes	No
Cataracts (Cloudy vision)			Cirrhosis (Liver problems)		
Glaucoma (Eye disease)			Colitis/Crohn's (Bowel problems)		
Chronic Sinus problems/congestion			Hepatitis: Type:		
Middle ear problems			Thyroid Disease		
Ear Surgery			Type I Diabetes		
Anemia (Tired, or low iron)			Type II Diabetes		
Hemophilia (Bleeding disorder)			End Stage Renal Disease (Kidney disease)		
Human Immunodeficiency Virus (HIV)			On Dialysis: Type:		
Lymphedema (Swelling in legs or arms)			Lupus (Problem with your immune system)		
Peripheral Arterial Disease (Problem with blood flow in your legs)			Raynaud's Syndrome (Problem with blood flow to your fingers or toes)		
Aspiration			Scleroderma (Skin disorder)		
Asthma (Breathing problem)			Rheumatoid Arthritis (Swelling of joints)		
Chronic Obstructive Pulmonary Disease (COPD)			History of Burn		
Pneumothorax (Collapsed lung)			Gout (Pain in big toes)		
Sleep Apnea (Stop breathing when sleeping)			Osteoarthritis (Pain in bones or joints)		
Tuberculosis (infection in the lungs)			Dementia (Memory loss that gets worse over time)		
Angina (Chest pain)			Neuropathy (Numbness in hands or feet)		
Arrhythmia (Skipped heartbeat)			Paraplegia (Can't move arms or legs)		
Atrial Fibrillation (Rapid heart rate)			Quadriplegia (Can't move arms and legs)		
Congestive Heart Failure			Received Chemotherapy		
Coronary Artery Disease (Heart disease)			Received Radiation		
Deep Vein Thrombosis (Blood clot in leg)			Surgery		
Hypertension (High blood pressure)			Anorexia/bulimia		
Hypotension (Low blood pressure)			Confinement Anxiety (Fear about being in a closed space)		
Myocardial Infarction (Heart attack)			Phlebitis (Inflammation of the veins in your legs)		
Sickle Cell Disease			Peripheral Venous Disease (Problem with blood vessels in your legs)		
Vasculitis (Inflammation of your blood vessels)					

Name of Person Completing Form: _____ **Relationship to Patient:** _____

Signature: _____ **Date:** _____ **Time:** _____

Reviewed By: _____ **Date:** _____ **Time:** _____

Patient History–Continued

Patient Label

Family Medical History (Please indicate with a checkmark if any of your family members have/had this condition)

Condition	Maternal Grandparents	Paternal Grandparents	Mother	Father	Siblings
Cancer					
Diabetes					
Heart Disease					
Hypertension					
Kidney Disease					
Lung Disease					
Seizures					
Stroke					
Tuberculosis					

Hospitalization/Surgery History (Please list all)

Name of Hospital	Reason You Were In the Hospital	Date

Please provide a list of your current medications or bring your current medications, including over the counter medications, herbal supplements and vitamins to the Wound Care Center® for your first visit.

For Healthcare Provider Use Only

Notes:

Name of Person Completing Form: _____ **Relationship to Patient:** _____

Signature: _____ **Date:** _____ **Time:** _____

Reviewed By: _____ **Date:** _____ **Time:** _____

New Patient Questionnaire
To be completed by Patient

Patient Label

Date: _____ **Time:** _____

Nutrition Risk Screen: Circle the number in the "Yes" column for those that apply and total nutrition score at bottom. **(Interventions are documented by Case Manager in the Care Plan.)**	**Yes**
I have an illness or condition that made me change the kind and/or amount of food I eat.	2
I eat fewer than two meals per day.	3
I eat few fruits and vegetables, or milk products.	2
I have three or more drinks of beer, liquor or wine almost every day.	2
I have tooth or mouth problems that make it hard for me to eat.	2
I don't always have enough money to buy the food I need.	4
I eat alone most of the time.	1
I take three or more different prescribed or over-the-counter drugs a day.	1
Without wanting to, I have lost or gained 10 pounds in the last six months.	2
I am not always physically able to shop, cook and/or feed myself.	2
This DETERMINE Health Screening Checklist was developed and distributed by the Nutritional Screening Initiative, a project of: American Academy of Family Physicians, The American Dietetic Association, National Council on the Aging, Inc.; Retrieved on line January 2019.	**Total:**

0 – 2: Low Risk	**3 – 5: Moderate Risk**	**6 and higher: High Risk**
No interventions needed	• Provide education on nutrition. • Provide education on elevated blood sugars and impact on wound healing, as applicable.	• Provide education on nutrition. • Provide education on elevated blood sugars and impact on wound healing, as applicable. • Obtain provider order for referral of patient for further nutrition evaluation.

Abuse Risk Screen: Check the appropriate answer for each question. (Interventions are documented by Case Manager in the Care Plan.)	
1. Has anyone close to you tried to hurt or harm you recently?	☐ Yes ☐ No
2. Do you feel uncomfortable with anyone in your family?	☐ Yes ☐ No
3. Has anyone forced you to do things that you didn't want to do?	☐ Yes ☐ No
If yes to any of the above questions, please explain:	

Falls Risk Screen: Check the appropriate answer for each question. (Interventions are documented by Case Manager in the Care Plan.)	
1. History of falling—immediate or within 3 months	25
2. Secondary diagnosis (Do you have 2 or more medical diagnoses?)	15
3. Ambulatory aid None/bed rest/nurse assist Crutches/cane/walker Furniture	 0 15 30
4. Intravenous therapy/Access/Saline/Heparin Lock	20
5. Gait/Transferring Normal/bed rest/wheelchair Weak (short steps with or without shuffle, stooped but able to lift head while walking, may seek support from furniture) Impaired (short steps with shuffle, may have difficulty arising from chair, head down, impaired balance)	 0 10 20
6. Mental status Oriented to own ability Overestimates or forgets limitations	 0 15
Agency for Healthcare Research and Quality National Center for Patient Safety. Morse Fall Scale; Retrieved online January 2019 ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool3h.html	**Total:**

Fall Risk Scale and Risk Level:	**0 – 24: Low Risk**	**25 – 50: Moderate Rvisk**	**51 and higher: High Risk**

Patient Signature: _____ **Date:** _____ **Time:** _____

Reviewed By Case Manage/Signature: _____ **Date:** _____ **Time:** _____

New Patient Questionnaire–Continued

Patient Label

Date: _____ **Time:** _____

Pain (Interventions are documented by Case Manager in the Care Plan.)
Pain present now? ☐Yes ☐No — **If No, skip rest of this section**.
With Dressing Changes: ☐Yes ☐No Location of pain:
Current Pain Level: 0 1 2 3 4 5 6 7 8 9 10 ☐ Unable to feel pain Duration of Pain: ☐ Constant ☐ Intermittent
Character of Pain: ☐Aching ☐Burning ☐Cramping ☐Exhausting ☐Easy to pinpoint ☐Sharp ☐Difficult to pinpoint ☐Dull ☐Heavy ☐Tender ☐Splitting ☐Throbbing ☐Shooting ☐Stabbing ☐Tiring ☐Other:
Pain Management: My pain is relieved by: ☐Medication ☐Rest ☐Heat Application ☐Leg Drop or Elevation ☐Activity ☐Massage ☐T.E.N.S ☐Cold Application ☐Other:
What is your Pain Management Goal? (Provide a pain level number between 1 – 10)
Is Current Pain Management Adequate? ☐Adequate ☐Inadequate

Wound Impact on Activites of Daily Living—Does your wound impact the following activities:					
Dressing/Bathing	☐Yes ☐No	Hygiene	☐Yes ☐No	Housekeeping	☐Yes ☐No
Eating	☐Yes ☐No	Ability to use phone	☐Yes ☐No	Laundry	☐Yes ☐No
Ambulating	☐Yes ☐No	Shopping	☐Yes ☐No	Handle medications	☐Yes ☐No
Toileting	☐Yes ☐No	Food Preparation	☐Yes ☐No	Handle money	☐Yes ☐No

Education (Interventions are documented by Case Manager in the Care Plan.)
Who will receive education on patient's wound or condition? ☐Patient **OR** ☐Caregiver—Name of Caregiver:
Learning preferences below are of the individual noted above.
Learning Preference: ☐Explanation ☐Demonstration ☐Video ☐Communication Board ☐Printed Material
Highest Education Level: ☐College or Above ☐High School ☐Grade School
Primary Language: ☐English ☐Spanish ☐Other: Preferred Language for Healthcare Information: ☐English ☐Spanish ☐Other:
Translator Needed? ☐Yes ☐No
Are there cultural/religious beliefs you have that would impact wound care— e.g. use of blood, porcine (pig) or bovine (cow) based tissue products? ☐Yes ☐No If Yes, please explain:
Impaired Vision: ☐No ☐Glasses ☐Contacts ☐Legally Blind
Impaired Hearing: ☐No ☐Complete Loss ☐Hearing Aid
What is your knowledge Level regarding your wound? ☐High ☐Medium ☐Low
What is your ability to understand written instructions? ☐High ☐Medium ☐Low
What is your ability to understand verbal instructions? ☐High ☐Medium ☐Low

Self Health Management (Interventions are documented by Case Manager in the Care Plan.)
Are you willing to engage in self-management activities? ☐Yes ☐No
Are you ready to engage in self-management activities? ☐Yes ☐No
Do you smoke tobacco or other substances? ☐Yes ☐No
Are you diabetic? ☐Yes ☐No
Nurse's Notes:

Patient Signature: _____ **Date:** _____ **Time:** _____

Reviewed By Case Manage/Signature: _____ **Date:** _____ **Time:** _____

Medication List

Pharmacy: _____ **Phone:** _____ **Fax:** _____

Allergies/Adverse Reactions/Sensitivities				
Date	**Time**	**Name of Allergies (Medication, Food, etc.)**	**Type of Reaction (Describe—e.g. itching, etc.)**	**Initials**

Directions: Enter date discontinued when applicable and rewrite new or changed medications on a new line. Provide initial copy to patient upon admission, with any changes and/or when patient is admitted to another organization that requires ongoing care. Upon discharge, provide copy to the patient along with education on the importance of sharing medication information with other care provider(s).

List all Over-the-counter medications (Includes vitamins/ minerals, herbal/natural products and recreational)									
Date	**Time**	**Medication**	**Dose**	**Frequency**	**Route**	**Purpose**	**Initials**	**Date Discontinued**	**Initials**

List all medications that patient reported as prescribed for them									
Date	**Time**	**Medication**	**Dose**	**Frequency**	**Route**	**Purpose**	**Initials**	**Date Discontinued**	**Initials**

Clinician Signature: _____ **Date:** _____ **Time:** _____ **Initials:** _____
Clinician Signature: _____ **Date:** _____ **Time:** _____ **Initials:** _____
Clinician Signature: _____ **Date:** _____ **Time:** _____ **Initials:** _____
Clinician Signature: _____ **Date:** _____ **Time:** _____ **Initials:** _____

Medication List–Continued

List all medications prescribed by Wound Care Center Provider(s)									
Date	**Time**	**Medication**	**Dose**	**Frequency**	**Route**	**Purpose**	**Initials**	**Date Discontinued**	**Initials**

Clinician Signature: _____ **Date:** _____ **Time:** _____ **Initials:** _____

Clinician Signature: _____ **Date:** _____ **Time:** _____ **Initials:** _____

Clinician Signature: _____ **Date:** _____ **Time:** _____ **Initials:** _____

Clinician Signature: _____ **Date:** _____ **Time:** _____ **Initials:** _____