INDY WOUND

CENTER FOR LIMB PRESERVATION
& RECONSTRUCTION

COMPREHENSIVE NEW PATIENT INTAKE, CONSENT & ACKNOWLEDGEMENT FORM
Practice Address: 8325 S Emerson Ave, Suite B-1, Indianapolis, IN 46237
Phone: 317-742-6575

SECTION 1: PATIENT DEMOGRAPHIC INFORMATION

Patient Name: ______________________________
Date of Birth: ______________________________
Age: ______________________________
Sex/Gender: ______________________________
Race/Ethnicity (optional): ______________________________
Marital Status: ______________________________
Address: ______________________________
City / State / ZIP: ______________________________
Primary Phone: ______________________________
Alternate Phone: ______________________________
Email: ______________________________
Preferred Contact Method: ☐ Phone ☐ Text ☐ Email
Preferred Language: ______________________________
Interpreter Needed: ☐ Yes ☐ No
Preferred Pharmacy Name: ______________________________
Address: ______________________________

SECTION 2: EMERGENCY & RESPONSIBLE PARTY INFORMATION

Emergency Contact Name: ______________________________
Relationship: ______________________________
Phone Number: ______________________________
Responsible Party (if not patient): ______________________________
Date of Birth: ______________________ Relationship: ______________________

SECTION 3: REFERRAL & PROVIDER INFORMATION

How did you hear about us? (check all that apply)

☐ Primary Care Provider ☐ Specialist ☐ Hospital/ER ☐ SNF/Rehab ☐ Google

☐ Social Media ☐ Family/Friend ☐ Insurance ☐ Other ____________________

Referring Provider / Facility: ____

Phone: ______________________________________ Fax: __________________________________

Primary Care Physician: _______________________ Phone: ________________________________

SECTION 4: AUTHORIZATION TO RELEASE HEALTH INFORMATION (ROI)

I authorize Indy Wound Center to use and disclose my protected health information as necessary for treatment, payment, and healthcare operations, including communication with:

Primary Care Provider: ____

Referring Providers: ____

Hospitals / ER: ____

Skilled Nursing / Rehab Facilities: ____

Home Health Agencies: ____

Family / Caregivers listed below:

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This authorization complies with HIPAA and applicable Indiana law and remains valid unless revoked in writing.

Patient Initials: __________

SECTION 5: INSURANCE & FINANCIAL RESPONSIBILITY

Primary Insurance: ____

Member ID: ____________________________ Group #: ________________________

Secondary Insurance (if applicable): ________________________________

☐ Copy of Insurance Card Provided ☐ Copy of Photo ID Provided

Assignment of Benefits & Financial Responsibility

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, Medicaid, and private insurance benefits, to Indy Wound Center for Limb Preservation & Reconstruction for services rendered.

I understand that I am financially responsible for all charges not paid by my insurance carrier, including deductibles, copayments, coinsurance, non-covered services, and out-of-network charges if applicable.

I understand that unpaid balances may be subject to billing statements, collection efforts, or credit reporting as permitted under Indiana law, and that I will be notified prior to any such action.

I understand that missed appointments or cancellations without adequate notice may result in a no-show or late cancellation fee, which is not billable to insurance and is my personal responsibility.

Patient / Responsible Party Initials: __________

SECTION 6: MEDICAL & SOCIAL HISTORY

Current Medications (include dose & frequency): ____________________________

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Medical Conditions (check all that apply):

☐ Diabetes (Type I / II)	☐ PAD / Circulation Problems	☐ Neuropathy
☐ Kidney Disease	☐ Dialysis	☐ Heart Disease
☐ Hypertension	☐ Stroke / CVA	☐ Osteomyelitis
☐ Prior Amputation	☐ Cancer________	☐ Lung Disease
☐ Liver Disease	☐ Venous Disease	☐ Thyroid Disorder
☐ Depression / Anxiety	☐ Other: ______________________	

Allergies (food/drug): ____

Social History:			
	Current Smoker:	☐ Yes	☐ No
	Alcohol Use:	☐ Yes	☐ No
	Recreational Drugs:	☐ Yes	☐ No

SECTION 7: WOUND & CURRENT CONDITION INFORMATION

Reason for Visit / Chief Concern:

____

____

Wound Location(s): ____

Wound Type(s): ____

Duration of Wound: ____

Prior Treatment: ☐ No ☐ Yes (Where?): ____________________

Signs of Infection: ☐ Yes ☐ No ☐ Unsure

Pain Description (if any):

☐ None ☐ Sharp ☐ Dull ☐ Burning ☐ Throbbing ☐ Numbness

SECTION 8: FUNCTIONAL, NUTRITIONAL & BARRIER ASSESSMENT

Mobility Assistance Needed: ☐ None ☐ Cane ☐ Walker ☐ Wheelchair

Unintentional Weight Loss: ☐ Yes ☐ No

Special Diet: ☐ No ☐ Yes: ____________________________

Barriers to Care (check all that apply):

☐ Transportation ☐ Financial ☐ Social ☐ Environmental

Explanation: ____

____

SECTION 9: ADVANCE DIRECTIVES (INDIANA-SPECIFIC)

Do you have Indiana-recognized advance directives, including a Living Will Declaration, Health Care Representative Appointment, or POST/POLST form? ☐ Yes ☐ No

SECTION 10: PATIENT RIGHTS, PRIVACY & ELECTRONIC COMMUNICATION

I acknowledge receipt of the Notice of Privacy Practices describing how my protected health information may be used and disclosed in accordance with HIPAA.

I understand that certain health information, including mental health records, HIV-related information, and substance use disorder treatment records, may be subject to additional protections under Indiana law and federal regulations (including 42 CFR Part 2).

Electronic & Telecommunication Consent
☐ I consent to receive appointment reminders, clinical communications, and billing notices via phone call, voicemail, text message, email, or patient portal. I understand standard messaging rates may apply.

☐ I decline electronic communications and request alternate contact methods.

SECTION 11: NO SURPRISES ACT DISCLOSURE

I acknowledge receipt of information regarding my rights and protections against surprise medical billing under federal law, including balance billing protections for emergency services and certain non-emergency services provided by out-of-network providers at in-network facilities.

SECTION 12: MEDICARE & DME SUPPLIES (IF APPLICABLE)

I acknowledge receipt of the Medicare Supplier Standards and understand that wound care supplies may be billed to my insurance and delivered to the address on file.

I understand that I may choose an alternate Medicare-approved supplier at any time.
☐ Accept ☐ Decline

SECTION 13: CONSENT FOR TREATMENT (INDIANA-COMPLIANT)

I authorize Indy Wound Center for Limb Preservation & Reconstruction to provide medical evaluation, wound care, procedures, diagnostics, and treatments deemed necessary and appropriate.

I acknowledge that the nature, purpose, benefits, risks, and alternatives of the proposed care have been explained to me in a manner consistent with Indiana Code §16-36-1 (Informed Consent), and that I have had the opportunity to ask questions, which were answered to my satisfaction.

This consent remains valid for all future visits unless revoked in writing.

SECTION 14: PHOTOGRAPHY & MEDIA AUTHORIZATION

☐ Clinical photography for medical documentation and treatment (required for care)

☐ Marketing / educational / promotional use (optional)

☐ I decline all non-clinical use

I understand that marketing or educational use of photographs or recordings is governed by Indiana's Right of Publicity statute (IC §32-36-1) and may be revoked in writing, except to the extent materials have already been used. *Declining marketing authorization does not affect treatment.*

SECTION 15: SIGNATURES

Patient / Legal Representative Signature: ______________________________
Printed Name: ______________________________
Relationship (if applicable): ______________________________
Date: ______________________________
Time: ______________________________

Signed in the State of Indiana

OFFICE USE ONLY

Date Received: ______________________
Appointment Scheduled: ______________________
Staff Initials: ______________________