Rafael Rafols, MD, CWSP
Certified Wound Care Specialist and Hyperbaric Medicine
Mission: 2009 E. Griffin Pkwy Mission, TX
OFFICE: (956)600-7747
FAX: 866-221-2183
www.thergvwounddoc.com

Date:________________

Patient's Name:_________________________________ Sex: (Circle One) Male / Female

Date of Birth:_________________________ Social Security #:_____________________

Address:____ State:_______ Zip:_________

Phone #:___________________________ Work Phone #:_____________________

Status: Single* Married* Divorced* Widowed*

Language Preferred:_______________________

Emergency Contact Name:___________________________

Relationship:_____________

Emergency Contact Phone #:_________________________

Primary Care Physician:____________________________ PCP Phone #:_____________

With whom may we share medical records?

Name:__________________________________

Relationship:______________________

Name:__________________________________

Relationship:______________________

Insurance Company:____________________________

ID#__________________________

Insurance Company:____________________________

ID#__________________________

Please remember that insurance is considered a method of reimbursing the patient for feed paid to the physician but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or an agreement we might have made with the insurer).

I authorize any holder of medical or other information about me to release to the SS# Administration and Center to Medicare and Medicaid Service or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts the assignment.

I have received this organization's privacy policies.

Signature:____ Date:________________

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CONSENT TO BE PHOTOGRAPHED

I, __________________________________, hereby consent to be photographed, by Dr. rafael Rafols / or his staff and _____________________________, during and after treatment.

I understand that these photographs shall remain in the property of the doctor and may be presented in scientific meeting sessions and/or shown for scientific, medical, or educational purposes.

I hereby consent that the doctor may use, at his discretion, my photographs for commercial / advertising purposes.

Signature:____ Date:________________

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General Consent for Care and Treatment Consent

TO THE PATIENT:
You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examination, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level practitioner (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform this practice. I understand that additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) procedures.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to this consent.

Signature of Patient or Personal Representative   Date

Printed Name of Patient or Personal Representative   Date

Printed Name of Witness   Date

Signature of Witness   Date

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If patient is unable to consent, or is a minor, complete the following:

Patient is unable to consent because:

Witness Signature   Legal Guardian, Healthcare Surrogate   Contact Phone #

PHYSICIAN'S CERTIFICATION:
I, Rafael Rafols, MD, CWSP, or his designee, hereby certifies that the patient or one authorized to act on his/her behalf:

1. Has been fully informed by me or my physician associates, in layman terms, understandable to the patient, the nature of the procedure, the medically acceptable alternatives to treatment including refusal, and the consequences and risks to the patient inherent or associated with the procedure(s).
2. Has authorized the performance of the procedure(s).

____
Signature of Rafael Rafols, MD, CWSP

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Consent for Procedure

Date: ____________

I authorize Dr.________________________, and such assistants as he/she may designate to perform upon ________________________ the following diagnostic procedure:

____

____

The nature of this procedure, possible alternative methods of treatment and the risks of infection despite precautions have been explained to me.

Signed __________________________________
(patient or person authorized to consent)

Witness __________________________________

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HIPPA Agreement

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information is information about you including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

Use and Disclosures of Protected Health Information. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in you care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed, to obtain payment for your health care services. For example, obtaining approval for hospital stay may require hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or attending for other business activities. For example, we may disclose your protected health information to medical school

students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you, we may use or disclose your protected health information, as necessary to contact you for your appointment.

You have the right to Inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following: psychotherapy notes; information compiled in reasonable anticipation of, or use in , a civil, criminal, or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may ask us to use or disclose any part of your protected health information for the purposes of treatment, payment, or health care operations. You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another health care professional.

You have the right to request confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. Upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the secretary of Health and Human Services if you believe your privacy rights have been violated by us . You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and became effective on/or before April 23, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by the phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy practices.
Print Name: ______________________________ Signature: ____________________________________

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Consent Form for Debridement of Wounds

Patient Name: ____

Dr. Rafael Rafols or his designee has discussed my medical problem with me and has explained the following procedure(s) to be undertaken in lay terms completely understandable to me. I understand that Dr. Rafols or his designee may designate assistant to assist him with the procedure listed below:

DEBRIDEMENT OF ANY AND ALL WOUNDS UNTIL FINALLY HEALED.

1. I have been fully informed of and understand the attendant risks and the possibility of complications, and the medically acceptable alternative to the above-described procedure(s) including the option to refuse such procedure(s). These risks or complications may include scarring, possible damage to blood vessels or surrounding areas such as organs, nerves, loss of blood or requiring a transfusion, allergic reactions, heart, liver, kidney or lung complications, infection and failure to heal.

2. I understand that this procedure initially may make the wound larger due to the removal of necrotic tissue from the margins.

3. I understand the risks and consent to the administration or transfusion of blood or blood components to me during my procedure and/ or its related treatment, whenever deemed necessary by those physicians attending to me, with no warranties made in connection with such blood or blood components.

4. If any unforeseen condition should arise during the procedure,I do hereby authorize and request Dr. Rafols and/or his associate(s) to take whatever steps necessary to perform whatever procedure(s) they deem advisable, which may be in addition to or different from those now planned and have been discussed with me.

5. I have been made fully aware and acknowledge that the practice of medicine and surgery are not exact sciences and that no guarantees or assurances have been made to me regarding expected outcomes.

6. I consent to the proposed procedure by the above physician(s) and (their) associates.

7. I consent to the taking of photographs or recording during the course of this procedure for the purpose of advancing medical education as may be authorized by my physicians and to the admittance of qualified observers to the operating/procedure room as determined by the facility.

8. There may be interns/students in the facility under the direct supervision of the surgeon.

I have read and I understand all the above, have had an opportunity to ask questions concerning the procedure and my questions have been answered to my satisfaction.

____

Signature of Witness

____

Signature of Patient

____

Date