BONA FIDE MEDICAL
WOUND + WELLNESS

Patient Demographics & Insurance

PATIENT INFORMATION

Today's Date: _____ / _____ / _____

Patient's Name: _____
First Middle Initial Last

DOB: _____ / _____ / _____ **SSN:** _____ - _____ - _____ **Sex:** ☐ Male ☐ Female

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ Multiracial ☐ Other: _____

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

Cell Phone: _____ **Home Phone:** _____

Preferred Method of Contact: ☐ Cell Phone ☐ Home Phone **Email Address:** _____

Employer: _____ **Employer Phone:** _____

How did you hear about our clinic? ☐ Internet ☐ Social Media ☐ Hospital ☐ Friend/Relative ☐ Other

Primary Insurance	**Secondary Insurance**
Carrier: _____	Carrier: _____
ID #: _____	ID #: _____
Group #: _____	Group #: _____
Name of Insured: _____	Name of Insured: _____
DOB of Insured: _____	DOB of Insured: _____
Relation to Insured: ☐ Self ☐ Spouse ☐ Other: _____	Relation to Insured: ☐ Self ☐ Spouse ☐ Other: _____

Referring Physician: _____ **Physician's Phone #:** _____

Primary Care Physician: _____ **Physician's Phone #:** _____

Nephrologist: _____ **Cardiovascular Surgeon:** _____

Preferred Pharmacy: _____ **Pharmacy Phone #:** _____

Emergency Contact Name: _____ **Relationship to Patient:** _____

Emergency Contact's Primary Phone #: _____ **Secondary Phone #:** _____

Home Health Company: _____

Durable Medical Equipment: ☐ None ☐ Wheelchair ☐ Walker ☐ Cane ☐ Shower chair ☐ Oxygen ☐ Bedside commode ☐ Other: _____

Initial Clinical History & Physical

Today's Date: _____ / _____ / _____

Patient First & Last Name: _____ **DOB:** _____ / _____ / _____

Chief Complaint: _____

When did your symptoms begin? _____

PRESCRIPTION MEDICATIONS

Current Medication	Dose	Frequency	Current Medication	Dose	Frequency

NON-PRESCRIPTION MEDICATIONS

Please list all over-the-counter medications, herbal medications or supplements that you take.

Current Medication	Dose	Frequency	Current Medication	Dose	Frequency

Patient's Last Name: _____ **Today's Date:** _____ / _____ / _____

PAST MEDICAL HISTORY

- ☐ None
- ☐ Active Dental Problems
- ☐ Alcoholism
- ☐ Allergy: Food
- ☐ Allergy: Seasonal
- ☐ Amputation
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis (Type / Location _____)
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Balance Problems
- ☐ Bleeding Tendencies
- ☐ Blood Clots (DVT)
- ☐ Bronchitis
- ☐ Cancer: Type / Location: _____
- ☐ Cataracts
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes – Diet Controlled
- ☐ Diabetes – On Insulin
- ☐ Diabetes – Oral Meds
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ Gastrointestinal Disease
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A, B, or C
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney Disease / Nephropathy
- ☐ Liver Disease
- ☐ Loss of Consciousness
- ☐ Lung Disease
- ☐ Lupus
- ☐ Neuropathy
- ☐ Obstructive Sleep Apnea
- ☐ Osteoporosis
- ☐ Parkinson Disease
- ☐ Peripheral Neuropathy
- ☐ Peripheral Vascular Disease
- ☐ Pneumonia
- ☐ Recent Fevers
- ☐ Recent Weight Loss
- ☐ Retinopathy
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Stroke/TIA
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Wears Glasses

ALLERGIES

Medication allergy	No Known Drug Allergies	Penicillin	Sulfa	Iodine	Latex
Reaction					
Medication allergy	Contrast dyes	Adhesive tape	Fish	Shellfish	Other (please specify)
Reaction					

PAST SURGICAL/HOSPITALIZATIONS HISTORY

Year	Type of Surgery/Hospitalization

Patient's Last Name: _____ **Today's Date:** _____ / _____ / _____

FAMILY HISTORY

Father	☐ Living ☐ Deceased	Age: _____	Medical History OR Cause of Death	☐ Unknown History ☐ Autoimmune Disease ☐ Bleeding Disorders ☐ Cancer: Type _____ ☐ Diabetes: ☐ Type I OR ☐ Type II ☐ Heart Disease ☐ High Blood Pressure ☐ Kidney Disease ☐ Lung Disease ☐ Stroke ☐ Other: _____
Mother	☐ Living ☐ Deceased	Age: _____	Medical History OR Cause of Death	☐ Unknown History ☐ Autoimmune Disease ☐ Bleeding Disorders ☐ Cancer: Type _____ ☐ Diabetes: ☐ Type I OR ☐ Type II ☐ Heart Disease ☐ High Blood Pressure ☐ Kidney Disease ☐ Lung Disease ☐ Stroke ☐ Other: _____

Patient's Last Name: _____ **Today's Date:** _____ / _____ / _____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have any children? ☐ Yes ☐ No If so, how many? _____

Do you complete your own self-care? *(Bathing, Eating, Grooming, Toileting)* ☐ Yes ☐ Requires Assistance

Support at home: ☐ Lives alone ☐ Lives with spouse/family ☐ Live with friends ☐ Lives at a facility

Exercise: ☐ None ☐ 1-2x/week ☐ 3-4x/week ☐ 5-7x/week Type: _____

Use of caffeine: ☐ None ☐ Occasional ☐ Daily How much? _____

Use of tobacco: ☐ Never ☐ Former Smoker: Quit how long ago? _____

☐ Current Everyday Smoker ☐ Vaping / E-cigarettes ☐ Pipe ☐ Cigars ☐ Chewing tobacco

Current cigarette packs per day: _____ How many years? _____

Use of alcohol: ☐ Never ☐ Socially ☐ Moderately ☐ Daily

Have you ever been treated for alcohol abuse? ☐ Yes ☐ No If yes, when? _____

Use of drugs: ☐ Never ☐ Type/Frequency: _____

Have you ever been treated for drug abuse? ☐ Yes ☐ No If yes, when? _____

Patient's Last Name: _____ **Today's Date:** _____ / _____ / _____

REVIEW OF SYSTEMS

Constitutional (General Health)
☐ Night Sweats
☐ Fever
☐ Chills
☐ Unintentional weight loss
☐ Difficulty sleeping
☐ Other: _____

Eyes
☐ Wear glasses or contacts
☐ Partial / complete blindness
☐ Vision changes
☐ Cataracts
☐ Glaucoma
☐ Other: _____

Ears, Nose, Throat
☐ Tinnitus (ringing in ears)
☐ Sore throat
☐ Dental problems
☐ Hearing Loss / Aid
☐ Other: _____

Respiratory
☐ Cough
☐ Shortness of breath
☐ Other: _____

Cardiovascular
☐ Irregular heartbeat
☐ Chest pain, angina
☐ Bleeding problems
☐ Blood clots
☐ Swelling arms or legs
☐ Other: _____

Gastrointestinal
☐ Bloody stools
☐ Changes in bowel movements
☐ Indigestion
☐ Nausea / vomiting
☐ Heartburn
☐ Other: _____

Genitourinary
☐ Urinary frequency
☐ Urinary incontinence
☐ Painful urination
☐ Blood in urine
☐ Other: _____

Skin
☐ Dermatitis – rash
☐ Ulcers
☐ Open sores or cuts
☐ Psoriasis or eczema
☐ Other: _____

Endocrine
☐ Diabetes
☐ Thyroid disorder
☐ Other: _____

Musculoskeletal
☐ Muscle weakness
☐ Deformities
☐ Joint swelling
☐ Joint Pain
☐ Difficulty moving arm/leg
☐ Other: _____

Neurological
☐ Headaches
☐ Loss of coordination / balance
☐ Falls
☐ Tingling
☐ Numbness
☐ Dizziness
☐ Memory loss
☐ Other: _____

Hematologic / Lymphatic
☐ Bruising
☐ Bleeding / clotting disorders
☐ Other: _____

Mental Health
☐ Depression
☐ Anxiety
☐ Other: _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

BONA FIDE MEDICAL
WOUND + WELLNESS

Authorization to Release or Obtain Medical Records

I, _____ DOB: _____

Patient's Name (Please Print)

Authorize: Bona Fide Medical
4455 S. Padre Island Dr., Ste. 13
Corpus Christi, TX 78411
(P) 361-248-2663 (F) 361-356-7420

TO OBTAIN INFORMATION FROM:

Name of Person or Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

TO RELEASE INFORMATION TO:

Name of Person or Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

I authorize the release of the following protected health information:
(Place an "X" in the box(es) that apply to this information you would like to release or obtain)

☐ Entire record ☐ Consultation notes/report ☐ Lab reports ☐ X-ray reports ☐ Surgical reports

☐ Medical History, Examination reports ☐ Treatment or test ☐ Hospital records including reports

☐ Other: _____

For personal copies of your medical records, the cost will be $25.00 for the first 25 pages and $0.25 for each page thereafter. Please allow 15 business days from the day of request to process your request for medical records.

Patient Signature: _____ Date: _____

BONA FIDE
MEDICAL
WOUND + WELLNESS

Consent and Disclosure for Medical and Therapeutic Procedures

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended therapies to be used so that you may make the decision whether to undergo the treatment after knowing the risks and hazards involved.

Consent to Treat: I understand that as a patient I have the right to make all decisions regarding my care. I voluntarily request Dr. Richard Barber as my treating Physician, and all associates with Bona Fide Medical, including but not limited to, Physician Assistants/Nurse Practitioners, Registered Nurses/Licensed Vocational Nurses, technical assistants, and other health care providers as deemed necessary, to treat my condition. I also understand that no warranty or guarantee has been made to me as to results or cures. I understand that my Physician and/or Physician Assistant/Nurse Practitioner may discover other or different conditions which require additional or different procedures than those planned. I authorize my Physician and/or Physician Assistant/Nurse Practitioner to perform such other procedures which are advisable in their professional judgment.

Risk and Emergency: Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the treatment.

Authorization to Release Information: I authorize Bona Fide Medical to release any and all healthcare information as necessary to (a) obtain payment from my Payers for my healthcare, (b) to conduct utilization review, peer review, and quality assurance, and (c) to other healthcare providers that will assist with my care. I understand that this information will identify me and may relate to my history, diagnosis, treatment, or prognosis; it will also include, where applicable, psychiatric, alcohol abuse, drug abuse, specific laboratory results of HIV or the diagnosis of AIDS. I understand that in the event of a healthcare worker is exposed to my blood or bodily fluids, my blood may be tested for the HIV antibody and other communicable diseases.

Financial Authorizations: I authorize all payers to pay Bona Fide Medical directly for the services provided. I assign to Bona Fide Medical my right to receive payment from third party payers. Third Party payers include anyone from whom benefits are or may become payable to me for services provided.

Receipt of Information: I acknowledge that I have received the "Notice of Privacy Practices" and a copy of "Patients Rights, Responsibilities and Healthcare Choices" from Bona Fide Medical. I certify this form has been fully presented and explained to me, that I have read it or have had it read to me, and that I understand its contents.

Financial Responsibilities: I understand and agree that I am responsible for payment of all charges that result from the care provided to me. I agree to pay these charges including payments not paid by my insurance company payers within 120 days. I understand that it is my responsibility to submit accurate insurance information on all dates of service and to comply with all requests of my insurance company within a timely manner to ensure payment is made within 120 days. I understand that if I am covered by Medicare / Medicaid, my obligation under this section may be limited by law.

Medication History: I authorize Medication History Retrieval from the National database.

Property: I understand that Bona Fide Medical does not assume responsibility for any personal property.

No Show/ Late Appointment Policy: I understand that 24 hours notice is required for appointment cancellations and that cancellations can and must be left on voicemail if after hours. After 3 No Shows on record, we reserve the right to conclude our relationship for noncompliance of stated office policy. If you are more than 15 minutes late for your scheduled appointment, you will need to reschedule your appointment. The practice runs on a tight schedule provide the best care for all in a timely manner.

Sunshine ACT Disclosure: In compliance with the Sunshine Act, a provision of the Affordable Care Act, we wish to disclose that our office occasionally receives food and beverages, sample drugs and patient coupons, and promotional material from pharmaceutical vendors and/or manufactures in conjunction with product education. We do not receive direct financial compensation from any of our vendors.

Photo and Video Consent/Disclosure: I understand that Bona Fide Medical and associates, such as Physician Assistant/Nurse Practitioner may photograph or video my wounds. I understand that the photograph and/or videos of my wound will be uploaded onto the electronic health record, and that I can view the photos or videos on the patient portal. I understand that these photographs and videos are to show me the progression of treatment of my wounds.

Consent and Disclosure for Medical and Therapeutic Procedures

Release of Medical Information

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below. I understand that I may request individuals leave the exam room at any time.

Name of Person who is **authorized to receive information:**	**Release Info.**		**Allowed in exam room**	
_____	☐ Y	☐ N	☐ Y	☐ N
_____	☐ Y	☐ N	☐ Y	☐ N

*If the requestor of information is not a healthcare provider, the released information may no longer be protected from re-disclosure.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON (signature required): By signing, you certify that this form has been fully explained to you, that you have been given the opportunity to ask questions, and that you fully understand its contents.

Signature: _____ Date: _____

Print Name: _____ Relationship: _____

Witnessed by: _____

Acknowledgment of Privacy Practices

I consent to the use/disclosure of my protected health information by **Dr. Richard Barber, PLLC,** hereby referred to as **Bona Fide Medical**. This disclosure is for the purpose of medical diagnosis, treatment, payment, and to conduct **Bona Fide Medical** health care operations.

I understand that my diagnosis/treatment by **Richard Barber, M.D. and/or other providers that are employed/contracted with Bona Fide Medical** is conditioned upon my consent as evidenced by my signature on this document. I understand that **Richard Barber, M.D. and/or other providers that are employed/contracted with Bona Fide Medical** may provide care to me in facilities in which they may have a financial interest.

I understand that I have the right to request a restriction as to how my protected health information is used/disclosed to carry out treatment, payment, or healthcare operations of the practices. **Bona Fide Medical** is not required to agree to the restrictions that I may request. However, if **Bona Fide Medical** agrees to a restriction that I request, the restriction is binding on Bona Fide Medical and myself, the patient.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Bona Fide Medical** has taken action in reliance on the consent.

My “Protected Health Information” means health information, including my demographic information, collected from me, and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Bona Fide Medical's** Notice of Privacy Practices prior to signing this document. The **Bona Fide Medical** "Notice of Privacy" Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Bona Fide Medical. The Notice of Privacy Practices for Bona Fide Medical is also available at the front desk of the clinic. This Notice of Privacy Practices describes my rights and the Bona Fide Medical duties with respect to my protected health information.

Bona Fide Medical reserves the right to change the privacy practices described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Portal User Agreement

Bona Fide Medical is pleased to provide a Patient Portal in partnership with our electronic medical records provider for the exclusive use of patients in our practice. The Patient Portal is designed to enhance patient – physician communication. All users must be established by a previous office visit.

We strive to keep all the information in your records correct and complete. If you identify any discrepancy in your records, you agree to notify us immediately. Additionally, by using the Patient Portal, the user agrees to provide factual and correct information.

The Patient Portal provides access to the following services, which may or may not be utilized at this time:

- Request prescription refills
- Receive educational material
- View current and past statements
- Send messages to clinical staff
- Receive health maintenance reminders

The Patient Portal is **not** intended to provide internet based diagnostic medical services. The following limitations also apply:

- No internet-based triage and treatment requests. Diagnosis can only be made, and treatment rendered, after the patient is SEEN by a medical provider in our office.
- No emergent communication or services. Any emergent conditions should be handled by calling the office directly, going to an urgent care clinic or emergency room or calling 911 should the emergency be life threatening.
- No requests for narcotic/controlled medications will be accepted.
- No requests for new prescriptions or refills for conditions for which you are not being treated by our clinic will be accepted.
- It may take 72 hours to receive a response to an email request. If you do not receive a response within 72 hours, you should contact the office at 361-248-2663.
- If you lose your password or username, you may request a new one through the web portal or in person at the office by providing valid identification.
- Always remember to logout and close your browser when you are finished accessing password protected Patient Portal services. This prevents someone else from accessing your personal information. **YOU SHOULD NEVER USE A PUBLIC COMPUTER TO ACCESS THE PATIENT PORTAL.**

This Patient Portal is provided as a courtesy to our patients. While some offices charge for this convenience on an annual basis, we are focused on providing the highest level of service and health care. However, if abuse or negligent usage of the Patient Portal persists, we reserve the right, at our discretion, to terminate Patient Portal offering, suspend user access and modify services available through the Patient Portal.

The Patient Portal is provided in partnership with our EHR software vendor and provider. The data is HIPAA compliant with high level encryption that exceeds the HIPAA standards. While we believe that the IT infrastructure and data are safe and secure, it does not guarantee unforeseen adverse events cannot occur. To the extent possible, our office has undergone rigorous IT implementation and security standards exceeding industry recommendations.

Please read our HIPAA policy for information on how private health information is used in our office. All patients have signed a HIPAA agreement form. If you do not recall having signed a HIPAA agreement or need to reacquaint yourself with the HIPAA policy, we will be happy to provide you with a copy.

Once you have signed the Patient Portal User Agreement and have provided our office with a legitimate email address that is secure, you will be given our system generated unique user identification and password. It is your responsibility to notify Bona Fide Medical if there is a change in your email address or if you feel your secure password has been breached.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form. I have been given risks and benefits of the Patient Portal and agree that I understand the risks associated with online communications between Bona Fide Medical and myself, and consent to the conditions outlined herein. I acknowledge that using the Patient Portal is entirely voluntary and will not impact the quality of care I receive should I decide against using the Patient Portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that Bona Fide Medical may impose for online communications. I have been given an opportunity to ask questions related to this agreement and all my questions have been answered to my satisfaction. I also understand this consent is valid for one year.

Authorization to Use and/or Disclose Protected Health Information for Media Release, Publication or Presentation

By signing below, I authorize *Bona Fide Medical Wound + Wellness* to distribute, publish, reproduce, edit, exhibit, and display, through any form of media (print, digital, electronic, social, broadcast or otherwise), the following: (i) my name, gender and age; (ii) any written work or the product of any interview that I have given to *Bona Fide Medical Wound + Wellness* or its agent; and (iii) images of me, including video and audio recordings, that have been taken or recorded at the request of *Bona Fide Medical Wound + Wellness* contest-related purposes or that I have provided to *Bona Fide Medical Wound + Wellness* (collectively, the "Materials").

I understand and agree that these Materials will become property of *Bona Fide Medical Wound + Wellness* and will be used for publication, promotional or educational purposes. I further understand and agree that I will not receive payment or other consideration for the Materials or their use.

Bona Fide Medical Wound + Wellness agrees not to sell or otherwise distribute the Materials for use by a third party unrelated to the promotional or educational purposes of *Bona Fide Medical Wound + Wellness*. I understand, however, that once the Materials have been published, a third party may gain access, republish, or use the Materials without seeking my permission.

I agree to hold harmless and forever release *Bona Fide Medical Wound + Wellness*, its representatives, employees, and agents, from any liability connected with or arising out of the use of the Materials. I may revoke (take back) this release by sending a letter that includes my name and address and identifies my Materials to *Bona Fide Medical Wound + Wellness* at 4455 S. Padre Island Drive, Suite 13, Corpus Christi, Texas, 78411. However, I understand that revoking the release will not affect any use of the Materials made before my revocation is received and processed, including any printed publications or displays in process at the time of revocation.

Please mark *ONE* of the boxes below:

☐ I ***ALLOW*** the release of any Materials for publication, promotional or educational purposes.

OR

☐ I ***DO NOT ALLOW*** the release of any Materials for publication, promotional or educational purposes.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON (signature required):

By signing, you certify that you have read the following forms, that the forms have been fully explained to you, that you have been given the opportunity to ask questions, and that you fully understand its contents:

(1) Consent and Disclosure for Medical and Therapeutic Procedures
(2) Acknowledgment of Privacy Practices
(3) Patient Portal User Agreement
(4) Authorization to Use and/or Disclose Protected Health Information for Media Release, Publication or Presentation.

Signature: _____ Date: _____

Print Name: _____ Relationship: _____

Secure/Private E-mail: _____

Once you have completed the form, please e-mail it to our office info@bfmtx.com.

You may call our office at (361) 248-2663 if you have any questions.

Thank you!

Bona Fide Medical Wound + Wellness
4455 S. Padre Island Drive, Suite 13
Corpus Christi, TX 78411
Phone: (361) 248-2663
Fax: (361) 356-7420
BFMTX.com