

Please fill in every box that applies to you. Leave a box empty if it does not apply.

Patient Information

First Name	Middle Name	Last Name	Jr/Sr
Street Address		Apt #	Zip Code
City, State	Home Phone	Cell Phone	
Email	Date of Birth (MM/DD/YYYY)		
Social Security Number	Gender		

Emergency Contact Information

Name	Relationship	Phone Number	Work Phone
Street Address	City, State, Zip Code		

Other Information

Preferred Language	Race	Ethnicity

Primary Care Provider

Doctor Name	Doctor Phone	Date Last Seen by Primary Doctor

Referring Provider (if different from Primary Care Provider)

Doctor Name	Doctor Phone	Date Last Seen by Referring Doctor

Primary Insurance Information

First Name of Insured	Last Name of Insured	Date of Birth of Insured
Social Security No. of Insured	Relationship	Gender of Insured
Insurance Company	Member ID Number	Group Number

Workers' Compensation (if this is a work injury)

Adjuster Name

Adjuster Phone

Date of Accident

Secondary Insurance Information

First Name of Insured

Last Name of Insured

Date of Birth of Insured

Social Security No. of Insured

Relationship

Gender of Insured

Insurance Company

Member ID Number

Group Number

Preferred Pharmacy

Pharmacy Name

Pharmacy Phone Number

Pharmacy Address

Payment and Authorization

FULL PAYMENT OR CO-PAYMENT IS DUE AT TIME OF SERVICE. AUTHORIZATION: I hereby authorize **CTWHA** and their medical staff to release information concerning my condition to my employer or their agent and hereby release those parties from any liability arising from such disclosure regarding this visit and any subsequent follow-up treatment (if this was a Workers Compensation case). If not a Workers Compensation case, I hereby assign **CTWHA** and its physician/healthcare staff all payment for medical services rendered. I further authorize **CTWHA** to perform any medically necessary treatment including laboratory studies and indicated tests, and authorize the release of any medical records for treatment purposes to those physicians to whom I am referred. I understand I am financially responsible for all charges incurred whether or not covered by my insurance.

I understand that there is a **\$50 fee** to fill out forms that are not covered by insurance such as disability or FMLA. I understand that if I do not cancel my appointment within 24 hours, or if I do not show up to my appointment, there is a **fee of \$35.00**.

Patient and/or Authorized Signature

Date

Written Consent: Consent to do Procedure, Anesthetics, and Other Medical Services

I,

authorize the performance of the following procedure(s), if necessary:

- Wound debridement with curette
- Tissue culture
- Wound debridement with ultrasound
- Other:
- Application of compression wraps
- Biopsy
- Skin substitute

1. I consent to the performance of procedures in addition to or different from those completed, whether or not arising from presently unforeseen conditions, which the above-named doctor or his associate or assistants may consider necessary or advisable in the course of the procedure.
2. I consent to the performance of wound debridement with curette or MIST to be done on a weekly basis for duration of wound in order to help remove devitalized tissue or bioburden.
3. I consent to the performance of compression wraps done at least once a week, sometimes twice a week, to help manage swelling to leg.
4. I consent to application of skin substitutes applied weekly to help achieve wound closure.
5. I consent to the administration of such anesthetics as may be considered necessary or advisable by the provider responsible for the service.
6. I consent to the photographing or television of the procedures to be performed, including appropriate portions of my body for medical, scientific or educational purposes.
7. For the purpose of advancing medical education, I consent to the admittance of observers to the procedure room.
8. The nature and purpose of the procedure, the possible alternative methods of treatment, the risks involved, the possible consequences and the possibility of complications have been explained to me by:

This explanation has been explained to me in a non-medical language in which I understand. I further acknowledge that the procedure is an elective, non-emergency type of therapy/surgery and that I have thought over all the information that has been given to me.

9. I acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained. Although an excellent result is expected, the possibility of complications could arise. Risks of this procedure include, but are not limited to:

- | | | | |
|------------------------|------------------------|-----------------------|------------------------------|
| a. Swelling | e. No improvement | i. Infection | m. Hematoma |
| b. Disability | f. Blood Clot | j. Numbness | n. Local anesthetic toxicity |
| c. Delayed Healing | g. Medication Reaction | k. Excessive bleeding | o. Nerve damage |
| d. Extended Discomfort | h. Injury | l. Joint stiffness | p. Paralysis |

The above has been explained to me in non-medical terms.

I acknowledge that all blank spaces on this document have been either completed or crossed off prior to my signing.

Patient Signature

Witness

Date

Emergency Contact

Emergency Contact Phone

Alternative Phone

Release of Medical Records

Patient Information

Patient Name

Date of Birth

Address

City, State, Zip Code

I, the undersigned, authorize Central Texas Wound Healing Associates to release my medical records as follows:

Records to be Released

☐ Complete Medical Record

☐ Specific Records – Please specify:

Purpose of Release

☐ Continuation of Care

☐ Personal Use

☐ Legal

☐ Other:

Recipient Information

Name of Recipient

Phone Number

Address

City, State, Zip Code

Expiration of Authorization

This authorization will expire on:

(If no date is specified, this authorization will expire one year from the date signed.)

Patient Rights

- I understand that I have the right to revoke this authorization at any time by providing written notice to Central Texas Wound Healing Associates.
- I understand that my records may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

Signature

By signing below, I acknowledge that I have read and understood this Release of Medical Records form and voluntarily authorize the release of my medical records as specified above.

Patient Signature

Date

If Signed by a Representative

Name of Representative

Relationship to Patient

Signature of Representative

Date

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.

If you have any questions about this Notice, please contact our office at 210-236-1886 or by mail at: 540 Madison Oak Drive, Suite 130, San Antonio, Texas 78258.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record.

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you.
- We will provide a copy or summary of your health information usually within 30 days of your request. We may charge a reasonable cost-based fee.

Ask us to correct your medical record.

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communication.

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share.

- You can ask us not to share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information.

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice.

- You can ask for a paper copy of this notice at any time. We will provide you with a paper copy promptly.

Choose someone to act for you.

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. A copy of this document must be provided to the office.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated.

- You can complain if you feel we have violated your rights by contacting us by calling the Privacy Line at 210-236-1886.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave. S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.
- Contact you for fundraising efforts.

If you are not able to tell us your preference, for example if you are unconscious or not present, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes

- Sale of your information
- Certain information regarding alcohol or drug abuse treatment
- Most sharing of psychotherapy notes

In the case of fundraising:

We may contact you for fundraising efforts, but you can tell us not to contact you again by writing the office.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you.

- We can use your health information and share it with other professionals who are treating you.
- *Example:* A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization.

- We can use and share your health information to run our practice, improve your care, and contact you when necessary. We can share your information with our business associates as described on this form.
- *Example:* We use health information about you to manage your treatment and services. We may use it to create de-identified health information to use for all lawful purposes.

Bill for your services.

- We can use and share your health information to bill and get payment from health plans or other entities.

Health Information Exchange.

- Health information exchange allows doctors, hospitals, and other health care providers to share health information about patients electronically. This is done for several purposes, including, but not limited to: treatment, quality assurance, state law reporting requirements, health care operations, and payment. Our providers and staff may share and receive your health care information electronically through various health information exchange connections with other health care providers.

How else can we use or share your health information? We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share

your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues.

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research.

We can use or share your information for health research.

Comply with the law.

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests.

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director.

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests.

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official, or certain information relating to inmates
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions.

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Business Associates.

There are some health-related services provided through contracts with third parties, called "business associates," that may need the information to perform certain services on our behalf. Examples include software or technology vendors we utilize to provide technical support, attorneys providing legal services to us,

accountants, consultants and others. When such a service is contracted, we may share your protected health information with such a business and may allow our business associates to create, receive, maintain or transmit your information on our behalf for the business associate to provide services to us, or for the proper management and administration of the business associate. Business associates must protect any health information they receive from, or create and maintain on behalf of, the Provider. In addition, business associates may redisclose your health information to subcontractors for the subcontractors to provide services to the business associate. The subcontractors will be subject to the same restrictions and conditions that apply to the business associate. Whenever such an arrangement involves the use or disclosure of your information, we will have a written contract that contains terms designed to protect the privacy of your information.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- If more stringent laws apply, they will be included in an addendum to this Notice.
- We will comply with State law. We would obtain your written consent for certain disclosures if your consent is required under State law.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

The effective date of this Notice is May 14, 2026.

This Notice of Privacy Practices applies to the following organization:

Central Texas Wound Healing Associates, PLLC
540 Madison Oak Drive, Suite 130
San Antonio, TX 78258
210-236-1886

ACKNOWLEDGMENT

I have read and understand the terms of this Notice.

Signature

Date



Medical History

Check the box next to each condition you have now or have had in the past.

- | | | |
|--|--|---|
| ☐ Alcoholism | ☐ Cognitive Impairment | ☐ Kidney Disease |
| ☐ Allergies/Hay fever | ☐ DVT (Blood Clot in Vein) | ☐ Kidney Infections |
| ☐ Anemia | ☐ Depression | ☐ Kidney Stones |
| ☐ Anxiety | ☐ Diabetes Type 1 | ☐ Migraines |
| ☐ Asthma | ☐ Diabetes Type 2 | ☐ Multiple Sclerosis |
| ☐ Atrial Fibrillation | ☐ Epilepsy | ☐ Heart Attack (Myocardial Infarction) |
| ☐ Blood Transfusions | ☐ Fracture | ☐ Obesity |
| ☐ CAD (Coronary Artery Disease) | ☐ Stomach Ulcer | ☐ Osteoarthritis |
| ☐ Cancer | ☐ Gastrointestinal Disease | ☐ Osteoporosis |
| ☐ Chemotherapy Date: <input type="text"/> | ☐ Acid Reflux (GERD) | ☐ Pneumonia |
| ☐ Radiation Date: <input type="text"/> | ☐ Gestational Diabetes | ☐ Progressive Neurological Disorder |
| ☐ Cardiac Pacer | ☐ Glaucoma | ☐ Prostate Cancer |
| ☐ Cardiovascular Disease | ☐ Heart Murmur | ☐ Pulmonary Disease |
| ☐ CHF (Congestive Heart Failure) | ☐ Hepatitis | ☐ Rheumatic Fever |
| ☐ Chicken Pox | ☐ High Cholesterol | ☐ Rheumatoid Arthritis |
| ☐ Chronic Renal Failure | ☐ Hyperlipidemia | ☐ Shingles |
| ☐ Cirrhosis | ☐ Hypertension | ☐ STD (Sexually Transmitted Disease) |
| ☐ Colitis | ☐ Hyperthyroidism | ☐ Terminal Illness |
| ☐ COPD (Chronic Lung Disease) | ☐ Hypothyroidism | ☐ Thyroid Disease |
| ☐ COVID-19 | ☐ Insulin Pump | ☐ TIA (Mini-Stroke) |
| ☐ Crohn's Disease | ☐ Joint Pain | ☐ Tuberculosis |
| ☐ CVA (Stroke) | ☐ Left Ventricular Systolic Dysfunction | ☐ Valvular Problems |

Hospitalizations

Dates	Hospital Name	Reason



Smoking Status

- | | | |
|---|---|--|
| ☐ Current every day smoker | ☐ Heavy tobacco smoker | ☐ Former smoker |
| ☐ Current some day smoker | ☐ Light tobacco smoker | ☐ Never smoker |

Family History

- ☐ I was adopted ☐ Family history unknown For each condition, check **Mother**, **Father**, or both.

Mother	Father	Condition	Mother	Father	Condition	Mother	Father	Condition
☐	☐	Alcoholism	☐	☐	Congenital Anomaly	☐	☐	Hypothyroidism
☐	☐	Alzheimer's	☐	☐	COPD (Chronic Lung Disease)	☐	☐	Kidney Disease
☐	☐	Anemia	☐	☐	Crohn's Disease	☐	☐	Liver Disease
☐	☐	Anxiety	☐	☐	Depression	☐	☐	Multiple Births
☐	☐	Asthma	☐	☐	Diabetes	☐	☐	Multiple Sclerosis
☐	☐	Birth Defects	☐	☐	Epilepsy	☐	☐	Osteoarthritis
☐	☐	CAD (Coronary Artery Disease)	☐	☐	Acid Reflux (GERD)	☐	☐	Osteoporosis
☐	☐	Cardiovascular Disease	☐	☐	Hypercholesterolemia	☐	☐	Pulmonary Disease
☐	☐	CHF (Congestive Heart Failure)	☐	☐	Hyperlipidemia	☐	☐	Stroke
☐	☐	Cancer – Type:	☐	☐	Hypertension	☐	☐	Substance Abuse

Do You Have Any of the Following?

- | | | | |
|----------------------------|--|---------------------------|--|
| Advance Directive: | ☐ Yes ☐ No | Living Will: | ☐ Yes ☐ No |
| Medical Power of Attorney: | ☐ Yes ☐ No | Do Not Resuscitate (DNR): | ☐ Yes ☐ No |

*Copy received (office use): Initials: Date: Time:

Wound History

Where is the wound?	Start Date
Has the wound ever healed and then reopened?	☐ Yes ☐ No Who has been treating the wound?
Have you had lab work done in the past month?	☐ Yes ☐ No Who ordered the labs?
Have you tested positive for an antibiotic-resistant germ (MRSA, VRE)?	☐ Yes ☐ No Date:
Have you tested positive for osteomyelitis (bone infection)?	☐ Yes ☐ No Date:
Have you had any tests for circulation in your legs?	☐ Yes ☐ No Where were the tests done?
Any other problem with the wound? (check all that apply)	☐ Infection ☐ Swelling ☐ Other:



How Did the Wound Start?

- | | | | |
|----------------------------------|---|---|---------------------------------------|
| ☐ Bite | ☐ Chemical Burn | ☐ Other Lesion | ☐ Surgical |
| ☐ Blister | ☐ Footwear | ☐ Pimple | ☐ Thermal Burn |
| ☐ Bruise | ☐ Frostbite | ☐ Pressure | ☐ Trauma |
| ☐ Bump | ☐ Gradually Appeared | ☐ Radiation Burn | ☐ Unknown |

Allergies

- | | |
|-------------------------|-------------------------|
| 1. <input type="text"/> | 2. <input type="text"/> |
| 3. <input type="text"/> | 4. <input type="text"/> |

List of Medications

Include the medicine name, the dose, and how often you take it.

- | | |
|--------------------------|--------------------------|
| 1. <input type="text"/> | 2. <input type="text"/> |
| 3. <input type="text"/> | 4. <input type="text"/> |
| 5. <input type="text"/> | 6. <input type="text"/> |
| 7. <input type="text"/> | 8. <input type="text"/> |
| 9. <input type="text"/> | 10. <input type="text"/> |
| 11. <input type="text"/> | 12. <input type="text"/> |
| 13. <input type="text"/> | 14. <input type="text"/> |
| 15. <input type="text"/> | |

List of Doctors and Phone Numbers

- | | |
|-------------------------|-----------------------------|
| 1. <input type="text"/> | Phone: <input type="text"/> |
| 2. <input type="text"/> | Phone: <input type="text"/> |
| 3. <input type="text"/> | Phone: <input type="text"/> |
| 4. <input type="text"/> | Phone: <input type="text"/> |
| 5. <input type="text"/> | Phone: <input type="text"/> |



Patient Name

Date of Birth

For each item, check **Yes** if you have this problem now, or **No** if you do not.

Yes No		Yes No		Yes No	
GENERAL		STOMACH		NEUROLOGICAL	
Headache	☐ ☐	Trouble swallowing	☐ ☐	Stroke	☐ ☐
Lethargy/Weakness	☐ ☐	Heartburn/Indigestion	☐ ☐	Seizures	☐ ☐
Chills/Night sweats	☐ ☐	Change in bowel habits	☐ ☐	Head injury	☐ ☐
Fever	☐ ☐	Loose Stool/diarrhea	☐ ☐	Memory loss	☐ ☐
Fainting spells/unconscious	☐ ☐	Black/Bloody Stools	☐ ☐	Confusion	☐ ☐
Weight loss	☐ ☐	Frequent stomach pain	☐ ☐	Trouble speaking	☐ ☐
Dizziness	☐ ☐	Vomiting blood	☐ ☐	Trouble swallowing	☐ ☐
EYES		Constipation	☐ ☐	Unsteady gait	☐ ☐
Wears glasses	☐ ☐	Irritable bowel	☐ ☐	Trouble walking	☐ ☐
Eyesight worsening	☐ ☐	Ulcers	☐ ☐	Arm/leg weakness	☐ ☐
Double vision	☐ ☐	Stomach/bowel cancer	☐ ☐	Arm/leg tingling	☐ ☐
Eye pain	☐ ☐	KIDNEY PROSTATE		Arm/leg numbness	☐ ☐
EARS/NOSE/THROAT		Frequent voiding	☐ ☐	PSYCHIATRIC	
Deafness	☐ ☐	Burning on urination	☐ ☐	Nervous breakdown	☐ ☐
Noise in ears	☐ ☐	Pus/blood in urine	☐ ☐	Panic attacks	☐ ☐
Congestion/sneezing	☐ ☐	Trouble starting urination	☐ ☐	Cry often/depressed	☐ ☐
Sinus trouble/hay fever	☐ ☐	Dribble with cough/sneeze	☐ ☐	Worry a lot	☐ ☐
Nose bleeds	☐ ☐	Loss of urine control	☐ ☐	Considered suicide	☐ ☐
Sore throat or tongue	☐ ☐	Prostate disease/cancer	☐ ☐	Loss of interest in eating	☐ ☐
Hoarse voice	☐ ☐	Sexual difficulty	☐ ☐	Anxiety/tension	☐ ☐
Dental problem	☐ ☐	SKIN		Loss of energy/fatigue	☐ ☐
HEART		Rashes	☐ ☐	ENDOCRINE	
Chest pain with exertion	☐ ☐	Birthmarks	☐ ☐	Unwanted weight change	☐ ☐
Heart attack	☐ ☐	Sores	☐ ☐	Change in skin	☐ ☐
Heart murmur	☐ ☐	Dry/oily skin	☐ ☐	Breast discharge	☐ ☐
Heart racing/palpitations	☐ ☐	Hair growth/loss	☐ ☐	Excessive thirst	☐ ☐
Irregular heart beat	☐ ☐	MUSCLE/BONE		Excessive tiredness	☐ ☐
Mitral valve prolapsed	☐ ☐	Back pain	☐ ☐	BREAST/MENSTRUAL	
High blood pressure	☐ ☐	Neck pain	☐ ☐	Endometriosis	☐ ☐
Swollen feet/ankles	☐ ☐	Back surgery	☐ ☐	Are you pregnant?	☐ ☐
Heart valve replacement	☐ ☐	Arthritis	☐ ☐	Irregular menstrual period	☐ ☐
Atrial fibrillation	☐ ☐	Fibromyalgia	☐ ☐	Breast discharge	☐ ☐
LUNG		Aching muscles/joints	☐ ☐	Lumps in breast	☐ ☐
Lung cancer	☐ ☐	Shoe lift or brace	☐ ☐	SLEEP	
Shortness of breath	☐ ☐	Bone/joint injury	☐ ☐	Dreams/sleep walk	☐ ☐
Chest pain	☐ ☐	Osteoporosis	☐ ☐	Legs twitch	☐ ☐



Review of Systems (continued)

		Yes	No			Yes	No			Yes	No
Coughing up phlegm		☐	☐	HEMATOLOGIC				Insomnia		☐	☐
Cough up blood		☐	☐	Blood disease		☐	☐	Daytime drowsiness		☐	☐
Wheezing/cough		☐	☐	Enlarged glands		☐	☐	Snores		☐	☐
Pneumonia		☐	☐	Bleed/bruise easily		☐	☐	Breath holding/gasping		☐	☐
				Anemia/low blood		☐	☐	Restless sleep		☐	☐

Signature

Date