Patient Name:

Consent Forms

Patient privacy, treatments/procedures, financial responsibility

CARE AND TREATMENT

I consent to treatment and care by the advanced practice providers, employees and/or authorized agents of Wound Wellness, PLLC. This will include procedures and treatment to heal my wounds. These treatments may include, but are not limited to, diagnostic laboratory procedures, medication administration, advanced wound care treatments and photographs/recordings. I understand that photographs/recordings made because of this consent may be used for the purposes of treatment, education, and training.

I consent to advanced practice providers, employees and/or authorized agents of Wound Wellness observing or shadowing my treatments for educational/training purposes. I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give informed consent for that procedure. If a procedure is needed or recommended, the medical provider will disclose the expected benefits and risks. Additionally, no research or experimental procedures will be done without my consent.

Patient signature on this form provides consent for your wound care provider to perform advanced treatments that may include sharp debridement, nail debridement, low-frequency non-contact ultrasound, total contact cast, application of skin substitutes, hyperbaric oxygen therapy, ankle-brachial index, EKG, chemical cauterization, punch or shave biopsy, pulse lavage, waived laboratory testing, wound vac placement, infrared therapy, E-stim therapy, and/or cultures.

HIPAA PRIVACY AUTHORIZATION

Authorization for Use and Disclosure of Protected Health Information

I authorize Wound Wellness to use and release my protected health information for treatment purposes, obtaining payment from third party payers, and other necessary operational purposes. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

COMMUNICATION/CONFIRMATIONS

I understand that the Wound Wellness care team, its representatives, and its agents may need to contact me regarding my care and treatment. I consent to receive calls, texts and e-mails about my ongoing care and treatment. I understand that I am not required to provide this consent in order to receive healthcare services. I understand that message and data rates may apply. I understand that my appointment may be canceled if confirmation of the upcoming appointment is not reciprocated.

ASSIGNMENT OF BENEFITS

The patient and/or the party responsible for the patient authorizes the patient's insurance company to pay directly to Wound Wellness on the patient's behalf for any service provided to the patient.

FINANCIAL RESPONSIBILITY

By signing below, the patient and/or the party responsible for the patient understands services being provided are necessary and appropriate. The patient/and or the party responsible for the patient understands that all charges are subject to review upon submission of a claim and that the subsequent responsibility of the patient and/or the party responsible for the patient will include any charges that are not covered by the insurance company, or amounts applied towards a deductible. The patient and/or the party responsible for the patient also understands that Wound Wellness will not waive any amounts applied towards a deductible if it has not been met yet. A Financial

Hardship Consideration form may be provided to the patient upon request, in the event the patient and/or the party responsible for the patient believes the patient qualifies for a payment plan for amounts applied towards deductibles. A Waiver of Copayment form may be provided to the patient upon request, in the event the patient and/or the party responsible for the patient believes the patient qualifies for financial hardship consideration.

Per Medicare protocols, patients are requested to complete an ABN (Advance Beneficiary Notice of Non-Coverage) form with select procedures/treatments. This form allows Medicare patients to review covered vs non-covered Medicare services to aid in an informed decision on treatment of the patient.

PATIENT NOTICE

1. **All information given to me, and all estimates made to the prospects of success and to the likelihood of occurrence of risk are made in the best professional judgment of my clinical provider. The possibility and nature of complications cannot always be accurately anticipated and, therefore, there is and can be no guarantee, either expressed or implied, as to the success or other results of the medical treatment or surgical procedure.**
2. **Nothing has been said to me, no information has been given to me, and I have not relied upon any information that is inconsistent with the information set forth in this document.**
3. **I have had the opportunity to disclose to and discuss with the clinical provider all information, risks, or other potential consequences of the medical treatment or surgical procedure that are of particular concern to me. I have had an opportunity to ask any question concerning the information in this document and any proposed treatment. My questions have been answered in a satisfactory manner.**
4. **In the event of occupational exposure, blood, or body fluid contact, I agree to follow Wound Wellness procedures, including but not limited to lab work and follow up.**

PATIENT CONSENT

I hereby authorize and direct the designated authorized clinical provider to administer or perform the medical treatment or surgical procedure described in this document, including any additional procedures or services as they may deem necessary or reasonable, including the administration of a regional anesthetic agent, x-ray or other radiological services, laboratory services, and the disposal of any tissue removed during a diagnostic or surgical procedure. My provider has explained all expected treatments and procedures including benefits and risks. I have read and understood all information set forth in this document, including any attachment, and all blanks were filled in prior to my signing. This authorization for and consent to medical procedure is and shall remain valid until revoked. I acknowledge that I have had the opportunity to ask any questions about the proposed medical procedure described in the document, including risks and alternatives, and acknowledge that my questions have been answered to my satisfaction.

PATIENT RIGHTS

The health and well-being of patients depends on a collaborative effort between patient and provider in a mutually respectful alliance. Patients contribute to this alliance when they fulfill responsibilities they have. to seek care. and to be candid with their providers. Providers can best contribute to a mutually respectful alliance with patients by se1ving as their patient's advocates and by respecting patients' rights. Another person selected by the patient can exercise these 1ights on the patient's behalf. A proxy decision can exercise these rights if the patient does not have a decision-making ability, is legally incompetent, or is a minor.

Respectful Treatment - The patient has the right to considerate and respectful care from your health care personnel and providers that do not discriminate against you. The patient has the right to receive medical care without regard to race or gender. age, disability, or sexual orientation.

Medical Care - The patient has the right to quality care and treatment consists of available resources and accepted standards. The patient has the right to make decisions about the care the provider recommends and to have those decisions respected. The patient also has the right to refuse a recommended treatment

or care plan to the extent allowed by the law and Government regulations, and to be informed of the consequences of his/her refusal. When there are concerns about medical care that was received. The patient has a right to request review of the adequacy of care.

Ask Questions - The patient has the right to ask questions about their health status or recommended treatment when they do not fully understand what has been described and to have their questions answered.

Privacy and Confidentiality - The patient has the right to every consideration of privacy. Expect that all communications and records relating to his/her care will be confidential, except in the case of suspected abuse and/or public health hazards when reporting information is necessary or required by the law.

Identity- The right to know. at all occurrences. the identity, professional status, credentials of the health care personnel and providers, as well as the name of the health care provider primarily responsible for his/her health.

Informed Consent - The patient has the right to be informed in non-clinical terms of information needed to make knowledgeable decisions on consent or refusal of treatments. Such information should be as following: significant complications, risk, benefits. and alternative treatments available.

Explanation of Care - The patient has the right to an accurate and easy-to-understand plan of care concerning his/her diagnosis, treatment, procedures. and prognosis or illnesses. The patient has the right to review the records about his/her care and to have the information explained or interpreted as necessary, except when restricted by the law.

Research Projects - The patient has the right to be informed if the facility proposes to engage in or perform research associated with his/her care of plan. The patient has the right to refuse participation in any research project.

Medical Records - The patient has the right to obtain copies or summaries of their medical records.

Second Opinion - The patient has the right to obtain a second opinion.

Conflicts of Interest – The patient has the right to be advised of any conflicts of interest their provider may have in respect to their care.

Continuity of Care – The patient should be able to expect that their provider will cooperate in coordinating medically indicated care with other health care professionals, and that the provider will not discontinue treating them when further treatment is medically indicated without giving them sufficient notice and reasonable assistance in making alternatives

arrangements for care.

PATIENT RESPONSIBILITIES

Providing Information – The patient has the responsibility to provide to their best knowledge, accurate and complete information about present symptoms, past illnesses, hospitalizations, medications, and other matters related to the patients' health.

Respect – The patient has the responsibility to respect the rights of other patients, health care personnel, and providers. The patient has the responsibility to be considerate on the property of other persons and of the facility.

Compliance – The patient has the responsibility to comply with his/her medical treatment plan, including follow-up care, recommended by health care providers. This includes keeping scheduled appointments and notifying the patient's Wound Wellness within 24 hours if any appointment needs to be rescheduled. The patient is responsible for: telling their providers or caregivers if they expect problems in following prescribed treatments; reporting all changes in their condition; to understand their health- if you have questions or need help understanding ask your provider or other medical staff members to discuss them with you. The patient must accept full responsibility for your decisions and your health care if you refuse treatment.

Print Patient Name_____

Patient/Authorized Party Signature_____**Date** _____

If consent is signed by someone other than the patient, state the reason why:

_____

***If consent is provided over the phone, 2 witnesses are required.**

Witness Signature_____**Date** _____

Second Witness Signature_____**Date** _____

CLINICAL PROVIDER

The undersigned clinical provider has explained to the Patient (or his/her legal representative), the nature of the treatment, benefits, risks, side effects, complications, and consequences which are/or may be associated with the treatment or procedure(s).

Clinical Provider_____**Date**

Authorization to Release Medical Information

Patient Name: _____ **Patient Date of Birth:** _____

I, _____**(*Name*), hereby authorize the release of my confidential health information by releasing a copy of my medical records or reports. I understand this information may include complete records, care plans, lab reports, treatment records, medication records, radiology reports, operative reports, and other summary of care.**

I AUTHORIZE THE RELEASE OF MY PROTECTED HEALTH INFORMATION TO:

Name: Wound Wellness, PLLC

Address: 50 S. Milwaukee Ave Ste 103

City: Lake Villa **State:** IL **Zip Code:** 60046

Phone: (224)215-6242 **Fax:** (224)842-0099 **Email:** info@woundwellness.net

This authorization will expire twelve (12) months from the date of signature.

_____ _____

Printed name of patient or authorized party **Date**

_____ _____

Signature of patient or authorized party **Date**

_____

Relationship to patient, if signed by authorized party