PATIENT CONSENT TO WOUND CARE TREATMENT

(Note: This form is to be signed by all Wound Care Center Patients. If Patient is going to receive Hyperbaric Oxygen Therapy, then Patient must also execute the Patient Consent to Hyperbaric Oxygen Therapy Consent Form).

PATIENT NAME: _____DATE OF BIRTH: _____
HOSPITAL: _____

Patient hereby voluntarily consents to wound care treatment by Physician, Hospital and its contractor HEALOGICS, INC. ("HI") and their respective employees, agents, representatives, and affiliated companies (hereinafter sometimes collectively referred to as Wound Care Center – "WCC"). Patient understands that this Consent Form will be valid and remain in effect from the date of signature, as long as Patient receives care, treatment and services at the Wound Care Center. A new consent will be obtained when a patient is discharged from the WCC and returns for care, treatment or services. Patient has the right to give or refuse consent to any proposed procedure or treatment at any time prior to its performance.

1. **General Description of Wound Care Treatment:** Patient acknowledges that Physician has explained that treatment in the WCC may include, but shall not be limited to: debridements, dressing changes, biopsies, skin grafts, off-loading devices, physical examinations and treatment, diagnostic procedures, laboratory work (such as blood, urine and other studies), x-rays, hyperbaric oxygen therapy, other imaging studies and administration of medications prescribed by a physician. Patient acknowledges that Physician has given Patient the opportunity to ask, Patient has asked, and Physician has answered all Patient's questions regarding the treatments that may be provided in the WCC.

2. **Benefits of Wound Care Treatment:** Patient acknowledges that Physician has explained that the benefits of treatment in the WCC include: enhanced wound healing and reduced risks of amputation and infection.

3. **Risks/Side Effects of Wound Care Treatment:** Patient acknowledges that Physician has explained that treatment in the WCC may cause side effects and risks including, but not be limited to: infection, ongoing pain and inflammation, potential scarring, possible damage to blood vessels, possible damage to surrounding tissues, possible damage to organs, possible damage to nerves, bleeding, allergic reaction to topical and injected local anesthetics or skin prep solutions, removal of healthy tissue, and prolonged healing or failure to heal.

4. **Likelihood of achieving goals:** Patient acknowledges that Physician has explained that by following the Physician's plan of care he or she is more likely to have a better outcome; however, any procedures/treatments carry the risk of unsuccessful results, complications, and injuries, from both known and unforeseen causes. Therefore, Patient specifically agrees that no representation made to him or her by Physician, Hospital or HI constitutes a **Warranty** or **Guarantee** for any result or cure.

5. **Alternative to Wound Care Treatment:** Patient acknowledges he or she has been made aware that he or she may refuse treatment in the WCC Patient acknowledges that if he or she refuses treatment in the WCC, he or she will not gain the benefits of treatment (see Benefits of Wound Care Treatment above). In lieu of treatment in the WCC, Patients may continue a course of treatment with his or her personal physician or forego any treatment.

6. **Benefit of Alternative to Wound Care Treatment:** Patient acknowledges that Physician has explained that if he or she chooses to continue a course of treatment with his or her personal physician or forego any treatment, he or she may not experience the risks/side effects associated with treatment in the WCC (see **Risks/Side Effects of Wound Care Treatment** above).

7. **Risks/Side Effects of Alternative for Wound Care Treatment:** Patient acknowledges that Physician has explained that the risks of alternative wound care treatment include prolonged healing or failure to heal, infection and possible amputation if wound is on a limb.

8. **General Description of Wound Debridements:** Patient acknowledges that Physician has explained that wound debridement means the removal of unhealthy tissue from a wound to promote healing. During the course of treatment in the WCC, multiple wound debridements may be necessary and will be performed by an authorized practitioner.

9. **Risks/Side Effects of Wound Debridement:** Patient acknowledges that Physician has explained that the risks or complications of wound debridement include, but are not limited to: potential scarring, possible damage to blood vessels or surrounding areas such as organs and nerves, allergic reactions to topical and injected local anesthetics or skin prep solutions, excessive bleeding, removal of healthy tissue, infection, ongoing pain and inflammation, and failure to heal. Patient specifically acknowledges that Physician has explained that bleeding after debridement may cause rapid deterioration of an already compromised patient. Patient specifically acknowledges that Physician has explained that drainage of an abscess or debridement of necrotic tissue may result in dissemination of bacteria and bacterial toxins into the bloodstream and thereby cause severe sepsis. Patient specifically acknowledges that Physician has explained that debridement will make the wound larger due to the removal of necrotic (dead) tissue from the margins of the wound.

10. **Patient Identification and Wound Images:** Patient understands and consents that images (digital, film, etc.), may be taken by the WCC of Patient and all Patient's wounds with their surrounding anatomic features. The purpose of these images is to monitor the progress of wound treatment and ensure continuity of care. Patient further agrees that their referring physician or other treating physicians may receive communications, including these images, regarding Patient's treatment plan and results. The images are considered protected health information and will be handled in accordance with federal laws regarding the privacy, security and confidentiality of such information. Patient understands that the WCC will retain the ownership rights to these images, but that the patient will be allowed access to view them or obtain copies according to state and Federal law. Patient understands that these images will be stored in a secure manner that will protect privacy and that they will be kept for the time period required by law and/or hospital policy. Patient waives any and all rights to royalties or other compensation for these images. Images that identify the Patient will only be released and/or used outside the WCC upon written authorization from the Patient or Patient's legal representative.

11. **Use and Disclosure of Protected Health Information (PHI):** Patient consents to HI's use of PHI, results of patient's medical history and physical examination, and wound images obtained during the course of Patient's wound care treatment and stored in the HI wound database for purposes of, education, research, quality assessment and improvement activities, and development of proprietary clinical processes and healing algorithms. Patient's PHI may be disclosed by HI to its affiliated companies, and third parties who have executed a Business Associate Agreement. Disclosure of Patient's PHI shall be in compliance with the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Patient specifically authorizes use and disclosure of patient's PHI by HI, its affiliates, and business associates for purposes related to treatment, payment, and health care operations. If Patient wishes to request a restriction to how his/her PHI may be used or disclosed, Patient may send a written request for restriction to HI's Chief Compliance Officer at 5220 Belfort Road, Suite 130, Jacksonville, Florida, 32256. If the PHI is owned by the Hospital or another entity, HI will direct Patient's request to the appropriate party.

12. **Financial Responsibility:** Patient understands that regardless of his or her assigned insurance benefits, Patient is responsible for any amount not covered by insurance. Patient authorizes medical information about Patient to be released to any payor and their respective agent to determine benefits or the benefits payable for related services.

The patient hereby acknowledges that he or she has read and agrees to the contents of sections 1 through 12 of this document. Patient agrees that his or her medical condition has been explained to him or her by the Physician. Patient agrees that the risks, benefits and alternatives of all care, treatment and services that Patient will undergo while a patient at the WCC have been discussed with Patient by Physician. Patient understands the nature of his or her medical condition, the risks, alternatives and benefits of treatment, and the consequences of failure to seek or delay treatment for any conditions. Patient has read this document or had it read to him/her and understands the contents herein. The Patient has had the opportunity to ask questions of the Physician and has received answers to all of his or her questions.

By signing below, Patient: (1) consents to the care, treatment, and services described in this document and orally by the Physician, (2) consents to the creation of images to record his or her wounds; and (3) consents to the transfer of health information protected by HIPAA between Physician, Hospital and HI.

_____ _____ _____

Patient Signature or parent (if minor) Relationship Date Time

_____ _____

Witness Signature Date Time

Interpreted/Translated by: _____ (if applicable) _____

Date Time

In the event above not signed by patient, the undersigned acknowledges that they have the legal right to sign the document.

_____ _____

Legal Guardian or Legal Representative Date Time

Printed Name: _____Relationship: _____

The undersigned Physician has explained to the Patient (or his or her legal representative), in layman's terms, the nature of the treatment, reasonable alternatives, benefits, risks, side effects, likelihood of achieving patient's goals, complications and consequences which are/or may be associated with the treatment or procedure(s).

_____ _____ _____

Signature of Physician Date Time