INFORMED CONSENT FOR WOUND CARE TREATMENT

Patient Name:____Date of Birth: ____________________

The patient hereby voluntarily consents to Wound Care Treatment by physicians at Advanced Clinician and their respective staff. Patient understands that this consent form will be valid and remain in effect as long as the patient remains active and receives services and treatments with Advanced Clinician. A new consent form will be obtained when a patient is discharged and returns for services and treatments. The patient has the right to give or refuse consent to any proposed service or treatment.

1. General Description of Wound Care Treatment: Patient acknowledges that physician has explained their treatment for wound care, which can include, but not be limited to: debridement's, dressing changes, biopsies, skin grafts, off-loading devices, physical examinations and treatment, diagnostic procedures, laboratory work (such as wound care cultures), request x-rays, recommend hyperbaric oxygen therapy, other imaging studies and administration of medications prescribed by a physician. Patient acknowledges that the physician has given them the opportunity to ask any questions related to the services or treatments being provided and that the physician answered all questions.

2. Benefits of Wound Care Treatment: Patient acknowledges that physician has explained the benefits of wound care treatment, which include enhanced wound healing and reduced risks of amputation and infection.

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

4. Likelihood of achieving goals: Patient acknowledges that physician has explained by following the proposed treatment plan they are more than likely to have optimized treatment outcomes; however, any service or treatment carry the risk of unsuccessful results, complications, and injuries, from both known and unforeseen causes.

5. General Description of Wound Debridement: 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, multiple wound debridement's may be necessary.

6. Risks/Side Effects of Wound Debridement: Patient acknowledges the physician has explained the risks and/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 removal of necrotic (dead) tissue from the margins of the wound.

7. Patient Identification and Wound Images: Patient understands and consents that images (digital, film, etc.) may be taken by Advanced Clinician of the 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 Advanced Clinician will retain ownership rights to these images, but 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. 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 Advanced Clinician upon written authorization from the patient or patient's legal representative.

8. Use and Disclosure of Protected Health Information (PHI): Patient consents to Advanced Clinician 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 Advanced Clinician 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 Advanced Clinician 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 Advanced Clinician 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 Advanced Clinician at mailing address 17503 La Cantera Pkwy # 104-404.

9. 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 9 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 with Advanced Clinician 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 his or her questions.

By signing below, patient consents to the care, treatment and services described in this document and orally by the physician, consents to the creation of images to record his or her wounds and consents to the transfer of health information protected by HIPAA. The Physician has explained to the patient (or his or her legal representative), 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).

Patient:

(Print) First and Last Name: ____

Signature: ____

Date: ____

Legal Representative (If patient is unable to sign for themselves):

(Print) First and Last Name: ____

Relationship to Patient: ____

Signature: ____

Date: ____

Office Use Only:

Witness:

(Print) First and Last Name: ____

Signature: ____

Title: ____