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 Patient's Medical Condition and Wound Care Treatment: Patient acknowledges that Physician has explained Patient's general medical condition to Patient. Patient further acknowledges that Physician has informed Patient that Patient's 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 questions, Patient has asked questions, and Physician has answered all of Patient's questions regarding the treatments that may be provided to Patient in the WCC.

2. Benefits of Wound Care Treatment: Patient acknowledges that Physician has explained that the potential benefits of treatment in the WCC may 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 involve risks including, but not 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 preparation 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 Physician's plan of care, Patient is more likely to have a favorable outcome; however, any procedures/treatments carry the risk of unsuccessful results, complications, and injuries, from both known and unforeseen causes. Therefore, Patient specifically acknowledges and agrees that no representation made to Patient by Physician, Hospital or HI constitutes a Warranty or Guarantee that Patient will experience any result or cure.

5. Refusal of WCC Treatment: Patient acknowledges that Patient has been made aware that Patient may refuse treatment in the WCC. Patient acknowledges that, if Patient refuses treatment in the WCC, Patient will not have the opportunity to experience the potential 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. Alternative to WCC Treatment: Patient acknowledges that Patient has been made aware that, in lieu of treatment in the WCC, Patients may continue a course of treatment with Patient's personal physician or forego any treatment. Patient acknowledges that Physician has explained that, if Patient chooses to continue a course of treatment with Patient's personal physician or forego any treatment, Patient may not experience the risks/side effects associated with treatment in the WCC (see Risks/Side Effects of Wound Care Treatment above). However, Patient may experience prolonged healing or failure to heal, infection and possible amputation if Patient's wound is on one of Patient's limbs.

7. 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.

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8. 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 preparation 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 (dead) 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 Patient's wound larger due to the removal of necrotic tissue from the margins of the wound.

9. Patient Identification and Wound Images: Patient understands and consents to having images (digital, film, etc.), taken 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 provide for continuity of care. Patient further agrees that Patient's referring physician or other treating physicians may receive medical information, including these images, regarding Patient's treatment plan and results. The images may be considered protected health information (PHI) and will be handled, maintained, and retained in a confidential, secure, and protected manner in accordance with applicable laws, regulations, and Hospital privacy and retention policies. Patient understands that the Hospital will retain ownership rights to these images and Patient expressly waives any and all rights to royalties or other compensation for these images. Patient understands that Patient may view or obtain copies of the images in accordance with applicable laws, regulations, and policies. 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.

10. Use and Disclosure of Protected Health Information (PHI): Patient authorizes and consents to HI's use of Patient's PHI, stored in the HI wound database for purposes of, education, payment and billing by the Hospital, quality assessment and improvement activities, and development of proprietary clinical processes and healing algorithms. PHI includes both medical and demographic information including, but not limited to, the results of Patient's medical history, physical examination, wound images, cell phone numbers and other contact information, and other information stored in HI's database. Patient's PHI may be disclosed by HI, in accordance with HI's agreement(s) with Hospital, to third parties providing services to HI and/or Hospital who have executed a business associate agreement or subcontractor agreement, with Hospital or HI. Any such disclosure of PHI that is not for treatment, payment, or operational purposes, shall be done in de-identified forms, unless otherwise permitted by law. Disclosure of Patient's PHI shall be in compliance with the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Hospital's Notice of Privacy Practices ("Notice"), and any applicable related law, rules, and regulations. 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 and as described in the Notice. For example, HI may disclose PHI to business associates or subcontractors for purposes such as auditing, quality assurance, payment, or other permissible purposes. Patient understands that, if applicable, PHI may include information relating to genetic conditions, HIV, mental health, substance abuse, and other sensitive conditions, and patient specifically authorizes that information to be used and disclosed as described in this form. 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 and/or maintained by the Hospital or another entity, HI will direct Patient's restriction request to the appropriate party.

11. Financial Responsibility: Patient understands that, Patient is responsible for any costs associated with Patient's treatment that are not covered by insurance. Patient authorizes Patient's PHI, as described above to be released to any payer, billing agents, and other third parties for payment purposes. For example, medical information may be disclosed to determine any insurance benefits or the benefits payable for services provided to Patient as part of Patient's treatment at the WCC.

Patient Initials: _____

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Patient hereby acknowledges that Patient has read this document or had it read to him or her, understands and agrees to the information set forth in this document, and has had the opportunity to ask questions and receive answers to questions about this document and the information set forth in this document.
By signing below, Patient: (1) consents to the care, treatment, and services explained to Patient by Physician and described in this document ; (2) consents to the creation of images to record Patient's wounds; and (3) consents to the use and disclosure of Patient's PHI as set forth in this document or as otherwise permitted by applicable laws, regulations, and policies.

_____ _____ _____ _____
Patient Signature or parent (if minor) Relationship Date Time

_____ _____ _____
Witness Signature Date Time

Interpreted by :_____(if applicable)

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 Patient (or Patient's legal representative), the nature of Patient's proposed treatment or procedure(s), reasonable alternatives to such treatment or procedure(s), likelihood of achieving Patient's goals with regard to such treatment or procedure(s), and the potential benefits, risk, side effects, complications and consequences relating to such proposed treatment or procedure(s).

_____ _____ _____
Signature of Physician Date Time

Patient Initials: _____