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 Treatment* 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.

General Description of Wound Care Treatment: Wound care treatment 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, other imaging studies and administration of medications prescribed by a physician.

Benefits of Wound Care Treatment: The benefits of treatment include: enhanced wound healing and reduced risks of amputation and infection.

Risks/Side Effects of Wound Care Treatment: May include, but not be limited to: infection, ongoing pain and inflammation, potential scarring, possible damage to blood vessels or surrounding areas such as organs and nerves, bleeding, allergic reaction to topical and injected local anesthetics or skin prep solutions, removal of healthy tissue, prolonged healing or failure to heal.

Likelihood of achieving goals: Patients who follow the physician's plan of care are more likely to have a better outcome, however, any procedure/treatments carry the risk of unsuccessful results, complications, and injuries, from both known and unforeseen causes, and no warranty or guarantee is made for any result or cure.

Alternative to Wound Care Treatment: A patient may refuse wound care treatment altogether, although the risks and side effects of doing so should be carefully considered. In lieu of treatment in the WCC, patients may continue a course of conservative treatment with their personal physician or forego any treatment.

Benefit of Alternative to Wound Care Treatment: The patient, who chooses to continue a course of conservative treatment with their personal physician or forego any treatment, may not experience the risks/side effects associated with treatment in the WCC (see **Risks/Side Effects of Wound Care Treatment** above).

Risks/Side Effects of Alternative for Wound Care Treatment: Risks of alternative wound care treatment include prolonged healing or failure to heal, infection and possible amputation if wound is on a limb.

General Description of Wound Debridements: Wound Debridement is the removal of unhealthy tissue from a wound to promote healing. During the course of wound treatment, multiple wound debridements may be necessary and will be performed by the authorized practitioner.

Risks/Side Effects of Wound Debridement: 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, bleeding, removal of healthy tissue, infection, ongoing pain and inflammation, and failure to heal. Patient understands that debridement may make the wound larger due to the removal of necrotic (dead) tissue from the margins of the wound.

Patient Initials: __________

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INTEGRIS Seminole Medical Center

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PATIENT CONSENT TO WOUND CARE TREATMENT

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Patient Consent to Wound Care Treatment

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. 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 part of the medical record 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. 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.

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 management activities, ongoing analysis, data aggregation 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.

Financial Responsibility: Patient understands that regardless of their 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's medical condition has been explained to the Patient. The risks, benefits and alternatives of all care, treatment and services that Patient will undergo while a patient at the WCC have been discussed. Patient understands the nature of their medical condition, the risks, alternatives and benefits of treatment, and the consequences of failure to seek or delay treatment for any conditions. Patient fully understands this consent to care, treatment, and services and agrees to its contents. The Patient has read this Consent Form or had it read to him/her. The Patient has had the opportunity to ask questions and has received answers to all of Patient's questions.

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