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 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 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 are 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 WCC 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 consents to HI's use of Patient's 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. HI agrees that HI will not use or allow use of Patient's PHI for any marketing or fundraising purposes without obtaining prior written consent from Patient for such use or uses. Patient's PHI may be disclosed by HI, with Hospital's prior knowledge and permission to its affiliated companies, and when necessary and appropriate to third parties providing services to HI and/or Hospital who have executed a Business Associate Agreement, with Hospital. Any such disclosure of PHI that is not for treatment, payment, or operational purposes, shall be done in de-identified forms. Disclosure of Patient's PHI shall be in compliance with the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 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. 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 medical information about Patient to be released to any payor and their respective agent to determine any insurance benefits or the benefits payable for services provided to Patient as part of Patient's treatment at the WCC.

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 Label

PATIENT CONSENT TO WOUND CARE TREATMENT

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 _____

WOUND CARE PATIENT BILLING INFORMATION

Our Wound Care Center® (WCC) serves as a hospital outpatient clinic where doctors and nurses treat people with wounds that they may have had for a long time. **Visits to the Center will result in charges from both the hospital and doctor.**

Many times these visits will only result in a charge for a procedure such as a wound debridement, but sometimes they may also include a clinic visit. Sometimes, there may be charges for hyperbaric oxygen therapy, laboratory tests, x-rays, and other services that may be performed in the hospital.

We understand this can be a confusing time and have outlined various ways the payment of the services provided to you can be handled. If you have questions about the process, please feel comfortable discussing this with one of the WCC staff members.

THE HOSPITAL:

When the hospital bills your insurance company(s) for the services you received at the WCC, the bill contains charges for what is called the **technical component**. This fee includes the use of the WCC's staff, room, equipment, etc. as well as any supplies that were used. You may also see laboratory charges, radiology (x-ray) charges, and other additional services if they were provided during that billing period. Some hospitals may bill for these additional services on a separate bill.

THE DOCTOR:

Each doctor that sees and treats you will bill separately for their services. Most of the time, this bill will come from his or her office, but sometimes hospitals may bill for the doctor's charges. These charges will be for the **professional component** and includes only the services that the doctor provided.

The WCC doctors are specially trained in providing wound care and the insurance companies know to pay for only one set of services by the codes used on the bill sent to them. They will pay a portion of the service to the hospital and a portion to the doctor. **You will not be billed twice for the same service** even though the description of the services may be the same.

OTHER DOCTORS:

There are different specialists who may be called in on your case, depending on the difficulty of your wounds, and they may submit a bill as well. These may be from the Pathologist for the professional component of the laboratory tests performed, or the Radiologist for the services rendered when x-rays were performed, etc.

These billing practices are consistent within all departments of the hospital as well as within the hospital industry. In addition, these billing procedures are frequently audited by Medicare/Medicaid and accepted as standard practice.

IF YOUR PRIMARY INSURANCE IS MEDICARE OR MEDICAID:

The hospital will bill Medicare/Medicaid and may send you a courtesy copy of your itemized bill upon request. Medicare/Medicaid will notify you when they have paid their portion of your hospital bill. If you have a secondary insurance, the hospital will also send them a bill for their portion and that company will contact you to let you know when and what they paid to the hospital. After payments are received by either your primary and/or secondary insurance, ***any outstanding balances will be your responsibility.*** This payment is necessary since the services were performed at a hospital outpatient department. If you are responsible for the co-payment balance, your payment may range from $15 - $82[1] per encounter depending on the services or HBO treatment rendered during your visit.

IF YOUR PRIMARY INSURANCE IS AN INDIVIDUAL / GROUP PPO OR HMO:

The hospital will bill your insurance company. You will be responsible for any deductible and/or co-payment amounts. Payment for these items may be expected at the time of service. Insurance verification will help us to identify your appropriate deductible and co-payment amounts.

IF YOU DO NOT HAVE INSURANCE COVERAGE:

Many hospitals require a payment (either in full or partial) at the time of the visit. If you are unable to pay, many hospitals will work with you to determine if you qualify for some type of assistance or will allow you to set up a payment plan. The center can refer you to the hospital's business office as needed. You cannot be seen in the WCC until these arrangements are completed.

IF YOU HAVE QUESTIONS REGARDING YOUR BILLS / STATEMENTS:

Please call the hospital's business office. Hours of operation are usually between 9:00 am and 4:30 pm (Monday thru Friday). If your question is regarding the physician's services, you will need to contact that physician's office.

Patient Signature:_____ Date:_____ Time: _____

Witness Signature:_____ Date:_____ Time: _____

[1]This cost estimate was made based on the date of this publication - 9/1/2012. This cost may vary after 2012.

PATIENT AUTHORIZATION

I authorize Betsy Johnson Regional Hospital, its staff and the physician(s) assigned to furnish the routine diagnostic and therapeutic procedures that are deemed necessary for the patient whose name appears on this form.

I assign insurance benefits and authorize payment of all hospitalization and medical benefits applicable and otherwise payable to me directly to Betsy Johnson Regional Hospital, and the physician(s) assigned to furnish the necessary medical and/or surgical treatments that are deemed necessary for the patient whose name appears on this form.

I authorize Betsy Johnson Regional Hospital, and the physician(s) assigned to furnish the necessary medical and/or surgical treatments that are deemed necessary to release medical or other information about this case to:

1. Other referral physicians.
2. The Patient's personal physician.
3. Blue Cross/Blue Shield, Medicare, Medicaid or other health insurance companies to complete the patient's hospitalization claim(s).
4. The appropriate governmental agency of the United States as such information may be required by Federal Law.

I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf for any services furnished me by or in Betsy Johnson Regional Hospital, including physician services.

The undersigned acknowledges that the account of the hospital does not include services of doctors treating or furnishing services to the patient, including but not limited to the Radiologists, Anesthesiologists, Emergency Department Physicians, Pathologists, and the like, and that the patient may expect to receive a separate statement or account from/for each such physician.

I understand that the practitioners in Anesthesia, the Emergency Department , Medical Imaging (Radiology) , Pathology and the Hospitalists are contracted and are not employees or agents of the Hospital. You will be receiving a separate bill for the providers of these services.

I authorize the refund of overpaid insurance benefits in accordance with my insurance policy conditions where my coverages are subject to a coordination of benefits clause.

I authorize that, as deemed necessary by the Radiologist or his designee, my imaging films and reports may be released.

I authorize Betsy Johnson Regional Hospital, Radiology Department, to forward my radiographic/imaging films and reports to any and all facilities upon request.

I authorize the Hospital to act in my behalf as attorney in fact in (1) the collection of benefits from any responsible third party through whatever means may be deemed necessary, and (2) in the endorsement of benefit checks made payable to myself and/or the Hospital.

I understand that the Hospital will hold on deposit any money or valuables for which the Hospital will issue a receipt. I also understand that the Hospital is not responsible for personal property retained in the patient's room.

I authorize any overpayment of this account be automatically applied to any unpaid account(s) at this Hospital in my name, guaranteed by me, and/or my immediate family. The balance, if any, may be applied against any balance due my attending physician(s) with any balance thereafter refunded directly to me.

I agree, should the account be referred for collection, to pay reasonable attorney's fees, court costs, and any and all other normal collection expenses that the Hospital and the physician(s) assigned to furnish the necessary medical and/or surgical treatments that are deemed necessary may incur.

_____
Printed Name of Patient

X_____
Signature of Patient

X_____ _____ X_____
Authorized Person – Relationship Date Witness to Signature

CONTRACT FOR MEDICAL SERVICES

In consideration for hospital services, specifically Wound Care rendered to _____ (Patient), the undersigned hereby unconditionally guarantees payment of all costs, charges and expenses to the hospital of every kind incurred by said patient during his/her admission/treatment. If any insurance applies to the services rendered to the patient, I understand that payment is due I full within 30 days of (a) denial of coverage by the carrier, (b) payment by the carrier, or (c) failure by the carrier to respond within 60 days of the last date of service, whichever occurs first. If no insurance applies, I understand that payment is due in full within 30 days of the last date of service. I further understand that, with the hospital's consent, I may pay this obligation through a third-party financing source which has been approved by the hospital. The undersigned agrees to the above terms and conditions and further agrees to be liable for all costs of collection including, but not limited to, court costs, interest charges, and reasonable attorney's fees.

X_____ _____ X_____
Signature of Guarantor Date Witness

Patient Label

PATIENT HISTORY

GENERAL INFORMATION		DATE:	
Name		Home Phone	
Address		Cell Phone	
City		State	Zip
▲ E-mail	Date of Birth	Age	Sex

SOCIAL HISTORY

Do you live alone: □ No □ Yes	Do you drive: □No □ Yes	Employed: □ No □ Yes
What is the highest school grade you completed? □ 1-6 □ 7-9 □ 10 □ 11 □ 12 □ Some college □ College graduate		
Marital Status: □ Separated □ Divorced □ Married □ Single □ Widowed		
Do you smoke: □ No □ Yes If Yes, for how many years:	How many packs per day:	If quit, when:
Do you drink alcohol: □ No History □ Prior History □ Current History		Type:
Do you use recreational drugs: □ No □ Yes If Yes, amount:		Type:
Caffeine Use: □ No □ Yes If Yes, for how many years:	How many cups per day:	
Financial Concerns: □ Yes □ No	Food/Clothing/Shelter Needs: □ Yes □ No	
Support System Intact: □ Yes □ No	Transportation Concerns: □ Yes □ No	

EMERGENCY CONTACT INFORMATION

Name	Home Phone
Relationship	Cell Phone

What physician suggested you visit the Wound Care Center®?

Name	Specialty	Phone	
Address	City	State	Zip

Who is your primary physician?

Name	Specialty	Phone	
Address	City	State	Zip

Please provide contact information (if applicable):

Home Health Agency:	Phone
Nursing Home/Skilled Nursing Facility:	Phone
Pharmacy:	Phone

Do you have any of the following?

Advance Directive: □ Yes* □ No	Living Will: □ Yes* □ No	Medical Power of Attorney: □ Yes* □ No	Do Not Resuscitate: □ Yes* □ No

*Copy required for chart. Requested by: _____ Date: _____ Time: _____

□ Copy provided. Signature: _____ Date: _____ Time: _____

Name of Person Completing Form: _____ Relationship to Patient: _____
Signature: _____ Date: _____ Time: _____

Reviewed By: _____ Date: _____ Time: _____

Patient Label

PATIENT HISTORY

WOUND HISTORY

Wound location:		
When did you first notice the wound?	Has it ever healed and then re-opened? ☐ Yes ☐ No	
How did your wound start? ☐Bite ☐ Blister ☐ Bruise ☐ Bump ☐ Chemical Burn ☐ Footwear ☐ Frostbite ☐ Gradually Appeared ☐ Not Known ☐ Other Lesion ☐ Pimple ☐ Pressure ☐ Radiation Burn ☐ Surgical ☐ Thermal Burn ☐ Trauma		
How have you been treating your wound until now?		
Have you had any lab work done in the past month? ☐ No ☐ Yes	If Yes, Who Ordered?	
Have you ever had bacteria that resisted antibiotics)? ☐ No ☐ Yes		If Yes, Date:
Have you ever had a bone infection? ☐ No ☐ Yes		If Yes, Date:
Have you had any tests for blood flow in your legs? ☐ No ☐ Yes		If Yes, Date:
If Yes, Where was it done:	Who ordered?	
Have you had any other problems with your wound? ☐ Infection ☐ Swelling ☐ Other		

PATIENT'S MEDICAL HISTORY (Please check Yes or No for each item)

	Yes	No		Yes	No
Cataracts (Cloudy vision)			Cirrhosis (Liver problems)		
Glaucoma (Eye disease)			Colitis/Crohn's (Bowel problems)		
Chronic Sinus problems/congestion			Hepatitis (Type:)		
Middle ear problems			Thyroid Disease		
Ear Surgery			Type I Diabetes		
Anemia (Tired, or low iron)			Type II Diabetes		
Hemophilia (Bleeding disorder)			End Stage Renal Disease (Kidney disease)		
Human Immunodeficiency Virus (HIV)			On Dialysis (Type:_____)		
Lymphedema (Swelling in legs or arms)			Lupus (Problem with your immune system)		
Sickle Cell Disease			Raynaud's Syndrome (Problem with blood flow to your fingers or toes)		
Aspiration			Scleroderma (Skin disorder)		
Asthma (Breathing problem)			Rheumatoid Arthritis (Swelling of joints)		
Chronic Obstructive Pulmonary Disease (COPD)			History of Burn		
Pneumothorax (Collapsed lung)			Gout (Pain in big toes)		
Sleep Apnea (Stop breathing when sleeping)			Osteoarthritis (Pain in bones or joints)		
Tuberculosis (infection in the lungs)			Dementia (Memory loss that gets worse over time)		
Angina (Chest pain)			Neuropathy (Numbness in hands or feet)		
Arrhythmia (Skipped heartbeat)			Paraplegia (Can't move arms or legs)		
Atrial Fibrillation (Rapid heart rate)			Quadriplegia (Can't move arms and legs)		
Congestive Heart Failure			Received Chemotherapy		
Coronary Artery Disease (Heart disease)					
Deep Vein Thrombosis (Blood clot in leg)			Surgery		
Hypertension (High blood pressure)			Anorexia/bulimia		
Hypotension (Low blood pressure)			Confinement Anxiety (Fear about being in a closed space)		
Myocardial Infarction (Heart attack)					
Peripheral Arterial Disease (Problem with blood flow in your legs)			Peripheral Venous Disease (Problem with blood vessels in your legs)		
Vasculitis (Inflammation of your blood vessels)			Phlebitis (Inflammation of the veins in your legs)		

FAMILY MEDICAL HISTORY (*Please indicate with a checkmark if any of your family members have/had this condition)*

Name of Person Completing Form:_____ Relationship to Patient:_____
Signature: _____ Date: _____ Time: _____

Reviewed By: _____ Date:_____ Time: _____
Reviewed By: _____ Date:_____ Time:_____

Patient Label

PATIENT HISTORY

HOSPITALIZATION/SURGERY HISTORY *(Please list all)*

Condition	Maternal Grandparents	Paternal Grandparents	Mother	Father	Siblings
Cancer					
Diabetes					
Heart Disease					
Hypertension					
Kidney Disease					
Lung Disease					
Seizures					
Stroke					
Tuberculosis					

NAME OF HOSPITAL	REASON YOU WERE IN THE HOSPITAL	DATE

Please provide a list of your current medications or bring your current medications, including over the counter medications, herbal supplements and vitamins to the Wound Care Center® for your first visit.

For Healthcare Practitioner Use Only

NOTES:

Name of Person Completing Form:_____ Relationship to Patient:_____
Signature: _____ Date: _____ Time: _____

Reviewed By: _____ Date:_____ Time: _____
Reviewed By: _____ Date:_____ Time:_____