ADVANCED
WOUND CARE

PATIENT CONSENT FOR WOUND CARE TREATMENT

PATIENT NAME: _____ DATE OF BIRTH: _____
(Printed)

Patient hereby voluntarily consents to wound care treatment by Advanced Wound Care Services LLC d/b/a Advanced Wound Care Services, and their respective employees, agents, representatives, and affiliated companies (hereinafter collectively referred to as "Advanced Wound Care Services"). 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 Advanced Wound Care 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 Wound Care Provider has explained that wound care treatment may include, but shall not be limited to: debridement, dressing changes, biopsies, skin grafts, off-loading devices, physical examinations and treatment, diagnostic procedures, laboratory work (such as blood, culture and other studies), other imaging studies and administration of medications prescribed by Wound Care Provider. Patient acknowledges that Wound Care Provider has given Patient the opportunity to ask, Patient has asked, and Wound Care Provider has answered all Patient's questions regarding the wound care treatments that may be provided.

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

3. **Risks/Side Effects of Wound Care Treatment**: Patient acknowledges that Wound Care Provider has explained that wound care treatment 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 Wound Care Provider has explained that by following the Wound Care Provider'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 Wound Care Provider/Advanced Wound Care Services 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 wound care treatment and Patient acknowledges that if he or she refuses wound care treatment, he or she will not gain the benefits of treatment (see Benefits of Wound Care Treatment above). In lieu of wound care treatment by Advanced Wound Care Services, Patient may continue a

course of treatment with his or her personal Provider or other Wound Care Provider or forego any treatment.

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

7. **Risks/Side Effects of Alternative for Wound Care Treatment:** Patient acknowledges that Wound Care Provider 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 Debridement:** Patient acknowledges that Wound Care Provider has explained that wound debridement means the removal of unhealthy tissue from a wound to promote healing. During the course of wound care treatment, multiple wound debridements may be necessary and will be performed by an authorized practitioner.

9. **Risks/Side Effects of Wound Debridement**: Patient acknowledges that Wound Care Provider 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 Wound Care Provider has explained that bleeding after debridement may cause rapid deterioration of an already compromised patient. Patient specifically acknowledges that Wound Care Provider 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 Wound Care Provider 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 photographs may be taken by Wound Care Provider/Advanced Wound Care Services of Patient and all Patient's wounds with their surrounding anatomic features. The purpose of these photos is for monitoring your condition, improving care, and ensuring the best possible outcomes. Photographs may also be used for educational purposes, training, and quality improvement within our practice. Patient further agrees that their referring Provider or other treating Wound Care Providers 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 Wound Care Services 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 Practice policy. Patient waives any and all rights to royalties or other compensation for these images.

I consent to the use of photographic images of my wounds, as follows:

Before and After Photographs: I agree to allow Advanced Wound Care Services to take photographs of my wound(s) before and after treatment to document and assess my progress.

Use of Images: I understand that these photographs may be used for the following purposes:

_____ (initial) Medical record keeping and monitoring my progress.

_____ (initial) Educational purposes within the practice.

_____ (initial) Presentation in medical training or professional education, including but not limited to publications, conferences, or online platforms.

Right to Withdraw Consent: I understand that I have the right to withdraw my consent at any time without affecting the quality of care I receive. If I wish to withdraw my consent, I will notify Advanced Wound Care Services in writing at compliance@awc-services.com.

Non-Consent to Use of Images:

_____ (initial) I do not consent to the use of my photographs for educational purposes, medical training, or promotional purposes, including on the Advanced Wound Care Services website or in publications. I consent only to the use of my photographs for care and treatment purposes.

11. **Use and Disclosure of Protected Health Information (PHI)**: Patient consents to Advanced Wound Care Services' 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 Wound Care Services' 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 Wound Care Services 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 Wound Care Services, 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 Wound Care Services at compliance@awc-services.com - If the PHI is owned by another entity, Advanced Wound Care Services 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's to be released to any payor and their respective agent to determine benefits or the benefits payable for related services.

13. **Open Payments Database Patient Notification**: The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov. For informational purposes only, a link to the federal

Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

ACKNOWLEDGMENT

Patient hereby acknowledges that he or she has read and agrees to the contents of sections 1 through 13 of this Consent for Wound Care Treatment. By signing below, Patient: (1) consents to the care, treatment, and services described in this document and orally by the Wound Care Provider/Advanced Wound Care Services, (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 Wound Care Provider and Advanced Wound Care Services.

_____ _____

Signature of Patient/POA Date

Relationship to patient if other than patient: _____

☐ If Patient / POA cannot complete form - verbal consent obtained in person or by phone.

Telephone Number: _____

Relationship to Patient: _____

Response to Consent: _____

Signature of person placing call: _____

☐ POA Documentation on File (if applicable) ☐ Interpreter used (if applicable)

_____ _____

Wound Care Provider Signature Date

_____ _____

Witness Signature Date