JUPITER MEDICAL CENTER

AGREEMENT TO RECEIVE WOUND CARE

Date: _____

This Agreement is Between _____ and _____
(Patient Name) (Provider Name)

I understand that I am being seen for wound care treatment in order to assist healing of my wound(s). This treatment is known to be effective only when provided on a regular basis. Lapses in my treatment, such as missed days or sporadic days, or failure to comply with the plan of care can result in this therapy becoming less effective or ineffective. Thus, I understand that in order for my treatment to be worthwhile, it is important that I receive treatment as scheduled and follow the treatment instructions provided.

I agree to the following conditions: (initial each line signifying agreement)

_____I will appear for treatment as scheduled.

1. If I am unable to appear for a scheduled appointment, I will notify the WCC staff by 8:00 AM on that day. I will, also, make every arrangement possible to reschedule for that same day during regular business hours.

2. If I fail to notify the center that I cannot keep my appointment within a minimum of 24-hours prior to, it will be considered a missed appointment.

_____I will follow the treatment instructions provided to me and I will actively seek assistance when I find myself unable to comply with the plan of care.

1. I agree to cleanse my wound and apply my dressing as directed by my provider
2. I agree to relieve pressure from my wound if prescribed by my provider.
3. I agree to use swelling control methods if prescribed by my provider.
4. I agree to follow good health practices of diet and exercise as advised by my provider.
5. If I am a smoker, I agree to participate in a program to help me stop smoking, because I realize that this habit may prevent or slow down my wound healing.
6. I agree that I am responsible for notifying the WCC staff immediately if I have any problems, questions or concerns regarding my wound and how I should care for it.

_____I understand that a violation of any of these conditions may result in my discharge from the WCC's program.

_____I agree to be an active participant in my care.

_____ _____ _____AM/PM
Patient Signature Date Time

_____ _____ _____AM/PM
Provider Signature Date Time