JUPITER MEDICAL CENTER

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 ("Patient"):_____DATE OF BIRTH: _____
HOSPITAL ("Hospital"): **Jupiter Medical Center Wound Healing Center**

You have the right, as a patient, to be informed about your condition and any recommended medical procedures so you can make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. By signing this Consent, Patient voluntary consents to receive wound care treatment provided by Hospital and its contractor Healogics, LLC. ("Healogics") and their respective employees, agents, representatives and affiliated companies (sometimes collectively referred to as a Wound Care Center ("WCC")). Patient understands that this Consent will remain in effect from the date this Consent is signed untilthe patient is discharged from receiving care, treatment, and services at the WCC. A new consent will be obtained if Patient is discharged from the WCC and returns for care, treatment, or services. Patient understands Patient has a right to give or refuse consent to any proposed procedure or treatment at any time prior to its performance. When a Patient is unable to consent to treatment (suchas because of incapacity or age), the term Patient below means the legal representative authorized to act on behalf of the person receiving treatment under this Consent.

1. **General Description of Patient's Medical Condition and Wound Care Treatment:** Patient acknowledges that Provider has explained Patient's general medical condition to Patient. Patient further acknowledges that Provider has informed Patient that Patient's treatment in the WCC may include, but is 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 provider. Patient acknowledges that Provider has given Patient the opportunity to ask questionsabout treatment, Patient has asked any questions Patient has about treatment, and Provider has answered all of Patient's questions regarding treatment that may be provided to Patient in the WCC.

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

3. **Risks and Side Effects of Wound Care Treatment:** Patient acknowledges that Provider 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 Provider has explained that, by following Provider'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. Patient specifically acknowledges and agrees that no representation made to Patient by Provider, Hospital or Healogics 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 any or all treatment in the WCC. Patient acknowledges that, if Patient refuses treatment in the WCC, Patient wi ll not receive certain advanced wound care therapies that might benefit the patient.

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 provider or may decide not to seek further treatment. Patient acknowledges that Provider has explained that, if Patient chooses to continue a course of treatment with Patient's personal provider or forego any treatment, Patient may not experience the risks and/or side effects associated with treatment in the WCC. Patient may experience prolonged healing or failure to heal, infection, and possible amputation if Patient's wound is on one of Patient's limbs.

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7. **General Description of Wound Debridements:** Patient acknowledges that Provider 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.

8. **Risks and Side Effects of Wound Debridement:** Patient acknowledges that Provider has explained the risks or complications of wound debridement include, but are not limited to, scarring, 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 Providerhas explained that bleeding after debridement may cause a patient who is already in poor health to get worse more rapidly than if the debridement had not been performed. Patient specifically acknowledges that Provider has explained that drainage of an abscess or debridement of necrotic (dead) tissue may cause bacteria and bacterial toxins to be released into the bloodstream and cause severe sepsis or septic shock. Patient specifically acknowledges that Provider has explained that debridement will make Patient's wound larger due to the removal of dead tissue from the edges of the wound.

9. **Patient Identification and Wound Images:** Patient understands and consents to having images (digital, film, etc.), taken of Patient and Patient's wounds with their surrounding anatomical features. These images are taken for treatment purposes, including for the ability to monitor the progress of wound treatment and to provide for continuity of care. 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.

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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 in this document, and has had the opportunity to ask questions and receive answers to questions about this documentand the information in this document.
By signing below, Patient consents to the care, treatment, and services explained to Patient by Provider and described in this document and consents to the creation of images of Patient's wounds…

Patient Signature or parent (if minor)	Relationship	Date	Time AM/PM

Witness Signature	Date	Time AM/PM

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 AM/PM

Printed Name:_____Relationship: _____

The undersigned Provider 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 Provider	Date	Time AM/PM

Patient Initials: _____