

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.

_____ **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(s) and apply my dressing as directed by my provider.
2. I agree to relieve pressure from my wound(s) 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.**

Patient Name/Signature: _____ **Date** _____ **Time** _____

Provider Name/Signature: _____ **Date** _____ **Time** _____

