AUTHORIZATION/CONSENT FOR WOUND CARE SERVICES

Wound Care Plus, LLC received a consult on your behalf to provide wound care services. The staff of Wound Care Plus, LLC (hereinafter "Wound Care Plus") provides wound care assessment, diagnosis, and treatment of wounds on site (i.e. in the patient's home or care setting). Patients who have wounds require treatment from healthcare professionals who are specifically trained and credentialed in wound care. Without treatment, wounds can become infected, necrotic, can be painful, and can worsen.

Prompt assessment and treatment by our trained wound care staff offers several benefits to patients and their families: (1) reduced need for costly transport to the doctor's office; (2) assist in wounds healing faster, getting back to a normal life sooner; (3) wounds heal faster, may reduce the need for hospitalizations or possible amputations; (4) pain from wounds and wound care decreases sooner; and (5) cost of wound care may be reduced due to faster healing times.

Medicare Part B, Medicaid, private insurance, and private payment cover the professional fees for these services. Under current rules, in order for Medicare Part B to pay, you must satisfy the annual allowable deductible. Part B will then pay 80% of the bill after the deductible has been met. The remaining 20% will be billed to a Medicare supplemental policy, Medicaid, or the person responsible for paying the patient's bills. Private insurances may also have an annual allowable deductible that must be satisfied before insurance will cover the cost of providers. You will need to complete this Authorization for Treatment before any services can commence.

AUTHORIZATION/CONSENT FOR TREATMENT

The patient, legal guardian, or health care surrogate; if any, hereby authorize Wound Care Plus and/or its agents to examine and treat if necessary, _____. This consent may be withdrawn at any time. Consent to treatment may include debridement (removal of unhealthy areas or tissue in and around the wound), tissue biopsy (for the purposes of diagnosis), tissue cultures (to determine if bacteria are present in the wound), application of skin substitutes, compression wraps, and/or other diagnostic tests and procedures. I have been informed of certain risks and possible consequences associated with procedures which include but are not limited to bleeding, infection, injury to nearby tissue/bone/organs, and wound complications. I am aware that the practice of medicine and wound care is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of any treatment or procedure. I am aware that I may ask any questions about these procedures and treatment at any time. I understand that any procedure may initially make the wound larger due to the removal of necrotic tissue from the margins of the wound. I consent to the procedures deemed medically necessary by my physician after consultation with Wound Care Plus.

CONSENT TO PHOTOGRAPH

I understand that photographs, digital images, or other images may be recorded to document my care, and I consent to the recording and retention of the images by Wound Care Plus. I understand that Wound Care Plus will retain the ownership rights to these photographs, digital images, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Would Care Plus's policy. Images used for education or research purposes will not have any

identifying patient information available to sources outside of Wound Care Plus. Images that identify me will be released and/ or used outside the Wound Care Plus upon written authorization from me or my legal representative.

ASSIGNMENT OF BENEFITS

In order to submit a claim for payment of service covered under Medicare Part B, Medicaid, or private insurance; we must have your authorization to release medical information to Medicare Part B, Medicaid, or your private insurance. As a Medicare participating provider, Wound Care Plus hereby accepts assignment for purposes of billing all Medicare covered services. According to Medicare guidelines the provider will always accept the amount that Medicare approves as full payment. Typically, Medicare pays 80% of this approved amount. Any supplemental insurance will also be billed as a courtesy. I hereby authorize the release of any information necessary to file a claim with my insurance company and assign any and all benefits to Wound Care Plus. However, if the insurance claim is denied for any reason, I will be responsible for payment of the charges.

MEDICARE

I request that payment of authorized Medicare benefits be made to Wound Care Plus. I authorize any holder of medical information to release to the Centers for Medicare and Medicaid Services ("CMS") and its agents and/or intermediaries any information needed to determine those benefits payable for related services. I hereby authorize CMS to furnish Wound Care Plus any information regarding Medicare claims under the Title XVIII of the Social Security Act, which Medicare may deny services considered by Medicare as routine. Services provided by Wound Care Plus may include, but are not limited to, conservative debridement and/or curettage, removal of bio-burden or necrotic tissue, collection of tissue samples, paring of calluses, and trimming of nails when necessary. Wound Care Plus will provide such requested services but the patient must be aware that Medicare and/or Secondary insurance may deny them as routine and you may ultimately responsible for the debt incurred.

HMO WAIVER

I have been informed that Wound Care Plus, LLC may not be a provider under my HMO Network insurance. Therefore, I have agreed to go out of network for the services provided by Wound Care Plus, LLC in the event it is not a covered provider under my HMO Network. In the event my HMO Network insurance will not pay for the services provided by Wound Care Plus, LLC, I will be personally responsible for the charges incurred.

I hereby understand the statements herein above and request service from the wound care physician with full knowledge that if my insurance does not pay for the requested services I am responsible for payment of the charges connected with the service. I have had this consent read to me and/or fully explained by the witness listed below.

Withdrawal of this consent must be in writing to Wound Care Plus and sent to one of the following addresses:

Wound Care Plus, LLC
210 NE Tudor Road
Lee's Summit, MO 64086

The patient, legal guardian, or health care surrogate, if any, has read and has had fully explained to him/her, and fully understands the above Authorization for Treatment. No guarantee or assurance has been made to the patient, legal guardian, or health care surrogate, if any, concerning the results which may be obtained.

This Authorization/Consent is to be governed by the laws of the State of Missouri.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of the wound care treatment and have received answers to my full and complete satisfaction. I have been given the opportunity to seek alternative methods of care and informed of the risks and benefits thereof. I do voluntarily assume any and all possible risks, including risk of substantial harm, if any, which may be associate with wound care treatment in the hope of obtaining the desired potential results, which may or may not be achieved. No guarantees or promises have been made to me concerning any results of the wound care treatment. In addition, the fee(s) for any and all services and treatment have been explained to me. By signing this form, I accept all terms and conditions expressed within it and freely give consent and authorization for Wound Care Plus, LLC to render/provide all wound care treatment deemed reasonably necessary by the treating physician.

_____
Patient Name (please print)

_____ Date:_____
Patient (or Authorized Legal Representative)

_____
If Legal Representative, Please State Legal Relationship – (ie. guardian)

Verbal/Telephone consent must be witnessed by two (2) licensed professional staff.

_____ _____
Licensed Staff Obtaining Consent (1) Facility Name

_____
Licensed Staff Obtain Consent (2)