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www.mywoundcareplus.com

AUTHORIZATION/CONSENT FOR ADVANCED WOUND CARE SERVICES

Wound Care Plus, LLC received an order for a consultation on your behalf to provide advanced wound care services. The staff of Wound Care Plus, LLC (hereinafter “Wound Care Plus”) provides wound care assessment, diagnosis, and treatment on-site or via telehealth (i.e., in the patient’s home or care setting). Patients with wounds require treatment from healthcare professionals specially trained in wound care. Wounds can become infected, necrotic, painful, and worsen without treatment.

Prompt assessment and treatment by our trained wound care providers offer several benefits to patients and their families: (1) reduced need for costly transport to the doctor's office or wound center; (2) wounds heal faster, getting back to everyday 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 these professional fees incurred from the service. Under current rules, for Medicare Part B to pay, you must satisfy the annual allowable deductible. Medicare 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 insurance may also have an annual allowable deductible that must be satisfied before insurance covers the cost of providers. **You must 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 authorizes Wound Care Plus and its agents to examine, evaluate, and treat, if necessary, the patient listed at the bottom of this document. This consent may be withdrawn at any time.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 diagnosis), tissue cultures (to determine if bacteria are present in the wound), application of skin substitutes, compression wraps, and 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 know 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 I will be allowed access to view them or obtain copies. I understand that these images will be stored securely to protect my privacy and will be kept for the time required by law or outlined in Wound Care Plus's policy. Images used for education, training, or research purposes will not have any identifying patient information available to sources outside of Wound Care Plus and its business associates providing products and services to Wound Care Plus. Images that identify me will be released and used outside Wound Care Plus and its business associates upon written authorization from me or my legal representative.

ASSIGNMENT OF BENEFITS

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. Wound Care Plus accepts the assignment to bill all Medicare-covered services as a Medicare-participating provider. According to Medicare guidelines, the provider will always accept the amount that Medicare approves as payment. Typically, Medicare pays 80% of this approved amount. Any supplemental insurance will also be billed as long as Wound Care Plus is supplied with the correct information. 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. I understand that if I cannot afford any uncovered amounts, I must notify Wound Care Plus and make financial arrangements.

I recognize that my failure to pay for my account in full and timely may result in my balance being placed with a collection agency. I further agree for you to service my account or to collect any amounts I may owe, your organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of your debt collection agency may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Your organization's representatives, ancillary providers, HIPAA business associates, vendors, and debt collection agency representatives may also contact me by sending text messages or emails using any e-mail address I provide to you. Contact methods may include using prerecorded/artificial voice messages and an automatic dialing device, as applicable. I have read this disclosure and agree that the Lender/Creditor, its ancillary providers, HIPAA business associates, vendors, and debt collection agents may contact me as described above.

MEDICARE

I request that authorized Medicare benefits be paid 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 intermediaries any information required to determine those benefits payable for related services. I hereby authorize CMS to furnish Wound Care Plus any information regarding Medicare claims under 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 curettage, removal of bioburden or necrotic tissue, collection of tissue samples, calluses paring, and nail trimming when necessary. Wound Care Plus will provide such requested services, but the patient must be aware that Medicare and secondary insurance may deny them as routine, and you may ultimately be 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, if it is not a covered provider under my HMO Network. If 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 above and request service from the wound care provider with full knowledge that if my insurance does not pay for the requested services, I am responsible for paying the charges connected with the service. I have had this consent read to me and fully explained by the witness listed below.

COMMUNICATIONS/NOTICES

Withdrawal of this consent must be in writing to Wound Care Plus. All communications or notices can be sent to:

Wound Care Plus, LLC
1100 NW South Outer Rd
Suite 200
Blue Springs, MO 64015-3069

The patient, legal guardian, or health care surrogate, if any, has read and 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 that may be obtained.

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

INFORMED CONSENT: I have been allowed to ask questions regarding the nature and purpose

of the wound care treatment and have received answers to my full and complete satisfaction. I have been allowed to seek alternative care methods and informed of the risks and benefits thereof. I do voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated 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.

PRIVACY NOTICE

It is the practice of Wound Care Plus, LLC (“Wound Care Plus”) that all individually identifiable health information is "Personal Health Information" (sometimes referred to as "PHI") and is protected under the Federal Privacy Rule, 45 CFR parts 160 and 164 (the HIPAA "Privacy Rules"). Wound Care Plus will not disclose any PHI to any other businesses or third parties for commercial, marketing, or sales purposes.

Patient information will regularly be used for treatment, payment, and internal operational purposes. Other allowable uses of your health information include services provided by business associates such as outside attorneys and billing services, imaging, and database services, or product providers such as durable medical equipment suppliers. To protect your health information, we require our business associates and providers to safeguard your information appropriately. Other than for the above purposes, a patient's PHI will not be used by Wound Care Plus or released to outside third parties without the patient's or their legally authorized representative's written authorization or as may be required by law. The patient may revoke authorization at any time. The patient has the right to and will receive notification in the event of a breach of unsecured protected health information.

Uses/Disclosures Relating to Treatment, Payment, and Health Care Operations

The following examples describe some, but not all, of the uses/disclosures made for treatment, payment, and healthcare operations.

For treatment - Consistent with its regulations and policies, Wound Care Plus may use/disclose PHI to doctors, nurses, service providers, and other personnel (e.g., interpreters) who are involved in delivering your health care and related services. Your PHI will help Wound Care Plus decide what services it may need to provide, assist in developing your treatment and service plan, and conduct periodic reviews and assessments. PHI may be shared with other healthcare professionals and providers to obtain prescriptions, lab work, consultations, and other items needed for your care.

To obtain payment - Consistent with the restrictions outlined in its regulations and policies, Wound Care Plus may use/disclose your PHI to bill and collect payment for your health care services. Wound Care Plus may release portions of your PHI to the Medicaid or Medicare program or a third-party payor to determine if they will make payment, get prior approval, and support any claim or bill.

For healthcare operations – Wound Care Plus may use/disclose PHI to support activities such as program planning, management and administrative activities, quality assurance, receiving and responding to complaints, compliance programs (e.g., Medicare), audits, training and credentialing of health care professionals, and certification and accreditation (e.g., The Joint Commission).

Uses/Disclosures Requiring Authorization

Wound Care Plus must have written authorization from you or your legally authorized representative with authority to make health care decisions on your behalf for uses/disclosures beyond treatment, payment, and health care operations unless an exception listed below applies. You may cancel an authorization at any time if you do so in writing. A cancellation will stop future uses/disclosures except to the extent Wound Care Plus has already acted based on your authorization.

Exceptions

- For guardianship or commitment proceedings when Wound Care Plus is a party
- For judicial proceedings, if certain criteria are met
- For protection of victims of abuse or neglect
- For research purposes, following strict internal review
- If you agree, verbally or otherwise, Wound Care Plus may disclose a limited amount of PHI for the following purposes:
 - **Clergy** – Your religious affiliation may be shared with clergy
 - **To Family and Friends** - Share information directly related to their involvement in your care or payment for your care
- For federal and state oversight activities such as fraud investigations, usual incident reporting, and protection and advocacy activities
- If required by law or for law enforcement or national security
- To avoid a serious and imminent threat to public health or safety
- For public health activities such as tracking diseases and reporting vital statistics
- Upon death, to funeral directors and certain organ procurement organizations

Although your health record is the property of Wound Care Plus, the information belongs to the patient. You have the following rights regarding your health information:

Right to Inspect and Copy. With some exceptions, you have the right to review and copy your health information. You must submit your request in writing to Wound Care Plus at the address indicated herein. A fee for the costs of copying, mailing, or other supplies associated with your request may be assessed upon each request for records.

Right to Amend. If you feel that health information in your record is incorrect or incomplete, you may ask us to amend or correct the information. Each request must include the specific health information to be amended or corrected (i.e., date of the record(s) and type of record(s)), the amendment or correction to be made, and the specific reason for the amendment or correction. You must submit your request in writing to Wound Care Plus at the address indicated herein. You have the right for as long as Wound Care Plus retains the information. If you feel that health information in your record is incorrect or incomplete, you may ask us to amend or correct the information. You must

submit your request in writing to Wound Care Plus at the address indicated below. You have this right for as long as Wound Care Plus retains the information.

We may deny your request for an amendment or correction if:

1. It is not in writing;
2. Does not include a reason to support the request;
3. Was not created by us;
4. Is not part of the health information kept by or for Wound Care Plus; or
5. Is not accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures related to your health information. This is a list of certain disclosures we made of your health information, other than those made for purposes such as treatment, payment, or health care operations.

You must submit your request in writing to Wound Care Plus at the address indicated below.

Your request must state a period no longer than seven (7) years before the date the request is submitted. Your request should indicate in what form you want the list (e.g., on paper or electronically). The first list you request within twelve (12) months will be free. We may charge you for additional lists for the cost of providing them. We will notify you of the cost involved, and you may choose to withdraw or modify your request before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you. For example, you may request that we limit the health information we disclose to someone involved in your care, the payment for your care, or your insurance company when you are paying in full. You could ask that we not use or disclose information about a surgery you had to a family member or friend.

We are not required to agree to your request. If we agree, we will comply with it unless the information is needed to provide your emergency treatment.

You must submit your request in writing to Wound Care Plus at the address indicated herein below to include the following: (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Alternate Communications. You have the right to request that we communicate with you about medical matters in a confidential manner or at a specific location. For example, you may ask that we only contact you via mail to a post office box. You must submit your request in writing to Wound Care Plus at the address indicated below. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice of Privacy Practices even if you have agreed to receive it electronically. You may ask us to give you a copy of this Notice at any time. You may obtain a copy of this Notice at our website, www.mywoundcareplus.com. To obtain a paper copy of this Notice, contact Wound Care Plus at the address indicated below.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice and to make the revised or changed Notice effective for the health information we already have about you and any information we receive in the future. We will post a copy of the current Notice on the website. The Notice will specify the effective date on the first page, in the bottom left-hand corner.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Wound Care Plus or the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing, and you will not be penalized for filing a complaint.

Patient Name (please print)

Patient Signature or Signature of Legal Representative

Name of Legal Representative (please print)

Date: _____

Relationship of Legal Representative to Patient

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

Signature of Licensed Staff Obtaining Verbal Consent (1)

Facility Name

Date: _____

Signature of Licensed Staff Obtaining Verbal Consent (2)