MEDICAL CARE INFORMED CONSENT

I, (patient) _____, or_____, as Patient Guardian/Representative (acting on his/her behalf), hereby authorize "Rhema Healthcare Services" to provide me with necessary medical services, treatments and diagnostic tests; to include any examinations, X-rays, laboratory procedures, tests, medications, medical treatment, sharp debridement, biopsies and/or other services rendered by the attending physician or other treating practitioners and their associates. I understand that this Consent Form will be valid and remain in effect from the date of signature, as long as Patient receives care, treatment and services from Rhema healthcare Services.

Medical Services: I recognize that the practice of medicine is not an exact science. I understand that no guarantees have been made as to the results from the treatment and care rendered by the assigned healthcare providers.

Wound Care Services: Wound care treatment may include, but shall not be limited to: sharp debridements, dressing changes, biopsies, skin grafts, off-loading, Negative Pressure therapy and compression devices.

Risks/Side Effects. May include, but not be limited to: infection, ongoing pain and inflammation, potential scarring, possible damage to blood vessels or surrounding areas such as organs and nerves, bleeding, allergic reaction to medications, removal of healthy tissue, prolonged healing or failure to heal.

Patient Identification and Wound Images: Patient understands and consents that images (digital, film, etc.), may be taken of Patient and all Patient's wounds with their surrounding anatomic features. Patient further agrees that their referring physician or other treating physicians may receive communications, including these images, regarding Patient's treatment plan and results. The images are considered part of the medical record and will be handled in accordance with federal laws regarding the privacy, security and confidentiality of such information. Patient understands that Rhema Healthcare Services will retain the ownership rights to these images, but that the patient will be allowed access to view them or obtain copies. Patient understands that these images will be stored in a secure manner that will protect privacy and that they will be kept for the time period required by law. Patient waives any and all rights to royalties or other compensation for these images. Images that identify the Patient will only be released and/or used outside the Rhema Healthcare Services upon written authorization from the Patient or Patient's legal representative.

Use and Disclosure of Protected Health Information (PHI): Patient consents to Rhema Healthcare Services use of PHI, results of patient's medical history and physical examination, and wound images obtained during the course of Patient's wound care treatment and stored in the Rhema Healthcare EMR for purposes of, education, research, quality management activities, ongoing analysis, data aggregation and development of proprietary clinical processes and healing algorithms. Patient's PHI may be disclosed by Rhema Healthcare to its affiliated companies, and third parties who have executed a Business Associate Agreement. Disclosure of Patient's PHI shall be in compliance with the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Financial Responsibility: Patient understands that regardless of their assigned insurance benefits, Patient is responsible for any amount not covered by insurance. Patient authorizes medical information about Patient to be released to any payor and their respective agent to determine benefits or the benefits payable for related services.

BY MY SIGNATURE, I ACKNOWLEDGE THAT I HAVE READ THIS FORM IN ITS ENTIRETY, THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS CONCERNING THE TREATMENT AND/OR PROCEDURE(S), THAT MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION, AND I AGREE TO ITS PROVISIONS AND CONSENT TO THE TREATMENT OR PROCEDURE(S) PROPOSED.

_____ _____ _____

Patient Signature **Date** **Time**

_____ _____ _____

Witness's Signature **Date** **Time**

If patient is unable to consent on his/her own behalf, complete the following:

_____ _____

Signature of legally responsible **Relationship to patient**

Provider's Signature :_____