Phone: 210-338-8616
Fax: 210-245-7861
Intake@gentlecare.health
www.gentlecare.health

Patient Registration and Consent Form

*Patient name:*_____ *Date of birth:* _____

*Home Address- Street:*_____

*City:*_____ *State:*_____ *Zip code:*_____

*Phone (home):*_____*E-mail address:*_____

Guardian/Authorized Representative information (if applicable):

*Name:*_____

*Home Address-Street:*_____

*City:*_____ *State:*_____ *Zip code:*_____

*Phone:*_____ *E-mail address:* _____

Patient Consent for Use and Disclosure of Protected Health Information and Mobile SMS Messaging

Patient hereby gives consent for Gentle Care Wounds and Wellness, LLC (hereafter sometimes referred to as "Practice") to use and disclose their protected health information (PHI) to perform treatment, payment, and healthcare operations (TPO). With this consent, Practice may contact Patient at home or other alternative location via phone, email, or mail, and leave a voice message or email or written notice in reference to any items that assist Practice in carrying out TPO, such as appointment reminders, insurance items, and anything pertaining to Patient's clinical care, including laboratory test results. Practice may mail to Patient's home or other alternative location any items that assist the practice in performing TPO, such as appointment reminders, billing statements, and anything pertaining to clinical care as long as they are marked "Personal and Confidential."

By signing this consent form, Patient consents to allow Practice use and disclosure of Patient's PHI to carry out TPO. Patient may revoke consent in writing except to the extent that Practice has already made disclosures upon Patient's prior consent. If Patient does not sign this consent, or later revokes it, Practice may decline to provide treatment to Patient.

Patient agrees to receive SMS text messages from Practice, related to services provided by Practice to Patient (please initial indicating YES or NO below):

_____ YES _____ NO If YES, please initial each section below to indicate consent. If NO, write "N/A."

____ Patient understands that they can text STOP at any time to opt out of receiving SMS text messages from Practice. Patient may text HELP at any time to receive help.

____ Patient's mobile information will not be shared with any third parties/affiliates for marketing/promotional purposes. All policies are followed as per CTIA guidelines 5.2.1. If at any time if Patient wants Patient information to be removed, Patient can contact Practice at intake@gentlecare.health.

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurance companies, contribute to the collection of this history. Some pharmacies do not make prescription history information available, and medication history might not include drugs that were purchased without the use of health insurance. Independently purchased over-the-counter drugs, supplements, and/or herbal remedies may not be included. Medication history can be very important in helping providers to treat symptoms and/or illness properly and avoid potentially dangerous pharmaceutical interactions.

Patient gives permission to healthcare provider to obtain medication history from Patient's pharmacy, health plans, and other health care providers. Patient understands that collected information is stored in Practice's electronic medical record system and becomes part of their personal medical record.

Patient acknowledges that it is important to disclose all medications in order to ensure medication history accuracy.

Consent to Wound Care Treatment

hereby voluntarily consents to wound care treatment by Gentle Care Wounds and Wellness, LLC and its respective employees, agents, representatives, and affiliated companies. Patient understands 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 at the Wound Care Center. A new consent will be obtained when Patient is discharged from Practice and returns for care, treatment or services. Patient has the right to give or refuse consent to any proposed procedure or treatment at any time prior to its performance. General Description of Wound Care Treatment: Wound care treatment may include, but shall not be limited to:

debridement (further described below), 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, other imaging studies, and administration of medications prescribed by a licensed provider.

Benefits of Wound Care Treatment: The benefits of treatment include: enhanced wound healing, and reduced risks of amputation and infection. Risks/Side Effects of Wound Care Treatment: 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 topical local anesthetics or skin prep solutions, removal of healthy tissue, prolonged healing or failure to heal.

Likelihood of achieving goals: Patients who follow the plan of care are more likely to have a better outcome; however, any procedures/treatments carry the risk of unsuccessful results, complications, and injuries, from both known and unforeseen causes, and no warranty or guarantee is made for any result or cure.
Alternative to Wound Care Treatment: A patient may refuse wound care treatment altogether, although the risks and side effects of doing so should be carefully considered. In lieu of treatment provided by Practice, patients may continue a course of conservative treatment with their personal physician or forgo any treatment.
Benefit of Alternative to Wound Care Treatment: The patient, who chooses to continue a course of conservative treatment with their personal physician or forego any treatment, may not experience the risks/side effects associated with treatment by Practice (see Risks/Side Effects of Wound Care Treatment above).
Risks/Side Effects of Wound Debridement: The risks or complications of wound debridement include, but are not limited to: potential scarring, possible damage to blood vessels or surrounding areas such as organs and nerves, allergic reactions to topical and injected local anesthetics or skin prep solutions, bleeding, removal of healthy tissue, infection, ongoing pain and inflammation, and failure to heal. Sometimes debridement may make the wound larger due to the removal of necrotic (dead) tissue from the margins of the wound.
Risks/Side Effects of Alternative for Wound Care Treatment: Risks of alternative wound care treatment include prolonged healing or failure to heal, infection and possible amputation if wound is on a limb.
General Description of Wound Debridements: Wound Debridement is the removal of unhealthy tissue from a wound to promote healing. During the course of wound treatment, multiple wound debridements may be necessary and will be performed by the authorized practitioner.

Telehealth Consent

I understand that my healthcare provider may conduct medical visits via telehealth, which involves the use of electronic communications to deliver healthcare services remotely. I acknowledge that: (1) Telehealth is a convenient and secure alternative to in-person visits (2) I have the right to withhold or withdraw consent to telehealth at any time without affecting my right to future care or treatment.(3) All confidentiality protections and privacy standards that apply to in-person care also apply to telehealth. I consent to receive medical services via telehealth when deemed appropriate by my provider.

Consent to Foot/Nail Care

Patient hereby voluntarily consents to receive foot and nail care services from Gentle Care Wounds and Wellness, LLC which may include, but are not limited to: Assessment of foot health, Nail trimming and debridement, Treatment of foot and nail conditions, and Education on foot care best practices.

Risks of Foot/Nail care: Patient understands and is informed that, as in all health care, in the practice of foot care there are some risks to treatment, including but not limited to discomfort/pain, swelling, and infection. Patient does not expect the Practice to be able to anticipate and explain all risks and complications and wishes to rely on the Practice and its representatives to exercise good judgement during the course of the procedure at the time, based on the facts known, and Patient's best interest.

Benefits of Foot/Nail Care: The benefits of receiving foot and nail care include improved foot health, prevention of complications, and education on maintaining foot hygiene.

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations
(§164.506(a) and §164.508(a))

Patient recognizes that as part of their healthcare, Practice originates and maintains health records describing Patient's health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. Patient understands that this information serves as:

- a basis for planning Patient's care and treatment;
- a means of communication among the health professionals who may contribute to Patient's healthcare;
- a source of information for applying diagnosis and surgical information to Patient's bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

Patient has been provided with a copy or directions for accessing a copy of the *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures.
Patient understands that as part of their care and treatment it may be necessary to provide Patient's PHI to another covered entity. Patient has the right to review Practice's *Notice of Privacy Practices* prior to signing this authorization.
Patient understands their right to:

- review Practice's *Notice of Privacy Practices* prior to signing this consent; object to the use of their health information for directory purposes;
- request restrictions as to how their PHI may be used or disclosed to carry out treatment, payment, or healthcare operations by sending a written request for restriction to Intake@gentlecare.health
- revoke this consent in writing at any time, except to the extent that Practice has already taken action in reliance thereon.
- Practice reserves the right to change the notice and practices and that prior to implementation Practice will mail a copy of any notice to the address I've provided, if requested.
- Practice is not required by law to agree to PHI restrictions requested.

Media Informed Consent and Release

Patient understands and consents that images (digital, film, etc.), may be taken by Practice of Patient and Patient's wounds with their surrounding anatomic features. Patient further agrees that their 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 Gentle Care Wounds and Wellness, LLC will retain the ownership rights to these images. 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 and/or Practice policy. Patient waives any and all rights to royalties or other compensation for these images. Images that identify Patient will only be released and/or used outside Practice upon written authorization from Patient or Patient's legal representative. Patient understands that Patient has the right to withdraw consent at any time. If Patient chooses to withdraw consent, Patient must inform Practice in writing. The consent remains valid until Patient withdraws it in writing. Patient has been provided with an opportunity to ask questions and clarify any concerns regarding the use of photographs for medical purposes. Patient consents for photographs and/or video images to be taken of them by Gentle Care Wounds and Wellness, LLC or a representative. Patient understands the images will be a part of the medical record and may be used for purposes of medical teaching or

for marketing purposes (website, print, digital or social media). Although photographs and/or video images will be used in an anonymous fashion without identifying information such as name, Patient understands it is possible someone may recognize them. The information, photographs, videos and/or testimonials disclosed under consent, or some portion thereof, are protected by state law and/or the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Any use or disclosure of such information, photographs, videos and/or testimonials carries with it the potential for an unauthorized redisclosure. Patient releases Practice and its agents and employees from all liability in connection with any such redisclosure and/or disclosure and/or use of information, photographs, videos and/or testimonials by individuals and/or entities other than Gentle Care Wounds and Wellness, LLC and its agents and employees. By consenting to photographs and/or video images Patient understands Patient will not be compensated in any way by any party. Patient further acknowledges that participation is voluntary and agrees that use of any photographs and/or video images confers no rights of ownership or royalties whatsoever. Patient waives any right to inspect or approve the information, photographs, videos and/or testimonials prior to use. Patient authorizes the use of photographs and/or video images (please initial indicating YES or NO below):

For educational purposes (medical teaching or training)

_____ YES _____ NO

For marketing and advertising purposes (website, print, digital, or social media)

_____ YES _____ NO

Patient hereby releases Gentle Care Wounds and Wellness, LLC, its employees, and any third parties involved in the creation of or publication of educational or marketing materials, from liability for any claims by Patient or any third party in connection with participation. By signing this form, Patient confirms understanding of this consent. If Patient wishes to withdraw consent in the future, Patient may do so via written request submitted to admin@gentlecare.health or by completion of a new form.

Revocation of consent will have no effect on any use or disclosure of photographs, videos or testimonials prior to revocation date. Refusal to agree to Release will not affect the medical treatment Patient receives from Practice.

Appointment Cancellation/No-Show and Transfer of Care Policies

Patient agrees to contact our office as soon as possible for appointment cancellation or rescheduling, and no later than **24 hours prior to their scheduled appointment**. This gives us time to schedule other patients who may be waiting for an appointment.

Any established patient who fails to attend or cancels an appointment, and has not contacted our office with at least 24 hours of notice shall be considered a “no-show” and may be **charged a $50 fee.** *The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next visit.*

As a courtesy, when time allows, we make reminder calls for appointments. In the absence of a reminder call or message, the above Policies will still remain in effect.

Upon a third no-show Patient may be dismissed from Practice. Any patients who cancel three or more consecutive appointments may be dismissed from Practice.

Gentle Care Wounds and Wellness, LLC, does not tolerate discrimination. Any abusive or offensive behavior directed at staff may result in dismissal from Practice.

Gentle Care reserves the right after assessment of the patient to refer Patient to another provider or clinic for care if Practice provider deems the level of care required by Patient is beyond the services and oversight offered by Practice. Patients with acute or severe symptoms may need to be transferred in order to ensure that the level of care they require is provided. Practice is not affiliated with any hospital, and patients who may have acute care requirements may be referred directly to a hospital or to a clinic or provider that partners with hospitals in the area. Patients who are referred to another clinic agree to follow up with the recommended clinic or provider to continue care, and that Practice will not continue services.

Financial Responsibility

Patient understands that regardless of their assigned insurance benefits, Patient is responsible for any amount not covered by insurance, such as copays, deductibles, and coinsurance. Patient assumes duty for understanding specifics of their insurance plan. 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.

Patient agrees to communicate timely with Practice in the event that Patient is unable to pay for any portion of service. The goal is to provide high quality care to all who need it, and Practice may be able to work with Patient to obtain financial assistance or set up payment plan. For questions regarding billing, please contact Admin@gentlecare.health

Acknowledgement of Consent

The Patient's medical condition has been explained to the Patient. The risks, benefits and alternatives of all care, treatment and services that Patient will undergo while a patient with Practice have been discussed. Patient understands the nature of their medical condition, the risks, alternatives and benefits of treatment, and the consequences of failure to seek or delay treatment for any conditions. Patient fully understands this consent to care, treatment, and services and agrees to its contents. The Patient has read this Consent Form or had it read to him/her/them. Patient has had the opportunity to ask questions and have them answered to Patient's satisfaction.

Patient Signature:_____Date:_____

In the event above not signed by patient, the undersigned acknowledges that they have the legal right to sign the document.

Legal Guardian/Representative Signature:_____Date:_____

Printed Name:_____ Relationship:_____