General Consent for Care, Treatment, and Procedures

This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment.

1. I _____consent_____to perform the following:
Last name, First name Eligible Provider or Clinician

☐Debridement- staged	☐Nail Excision	☐Incision and Drainage	☐Silver Nitrate
☐G-Tube Replacement	☐Compression	☐Skin/Wound Biopsy	☐Other

Location of Procedures: _____

2. The Patient's or the responsible party has acknowledged that they understand the procedure in their own words.

3. I consent to the performance of procedures in addition to or different from those now contemplated but are necessary or advisable in the course of the operation due to unforeseen circumstances or Emergencies.

4. Assistants: I understand the procedure may be performed with the assistance of other health care professionals.

5. Debridements may be performed periodically (usually weekly) on the wound's described above without need for further consent.

6. Photographs: I consent to use of photographs that may be used for documentation or teaching purposes.

7. I consent to disposal of tissue and or blood products as a result of the procedure.

8. General Risks: I understand there is a risk of bleeding, infection, pain, loss of body function, paralysis, allergic reaction or even death. Although these risks are rare, the provider will use techniques that are standard within the industry to minimize any risks. The advantage of the procedure has been explained and the disadvantage of not performing the procedure.

9. Alternative procedures have been explained (if applicable) and their possible risks and benefits.

10. I have the right to have a second opinion.

11. No Guarantees: I understand there are risks involved in any procedure or treatment, and it is not possible to guarantee or give assurance of a successful result.

Advantage SURGICAL & WOUND CARE

General Consent for Care, Treatment, and Procedures

12. Telemedicine Consultations: I have the right to choose if I would like to have a consultation done via telemedicine and the right to stop the consultation at any time.

The eligible provider or clinician has the right to request the patient to be seen face to face if enough patient information cannot be obtained via telemedicine to provide a diagnosis.

Photography and secure messaging may be used for telemedicine documentation

13. ASSIGNMENT OF INSURANCE BENEFITS / RELEASES OF INFORMATION *Advantage Surgical & Wound Care (Robert Marriott Medical Corp.), may disclose all or part of my medical record to a hospital, medical service company, insurance company, worker compensation carrier, welfare fund or my employer.*

I hereby authorize my insurance company/fund to pay benefits for this and subsequent visits directly to Advantage Surgical & Wound Care or its designee. In addition, I request that payment of authorized Medigap benefits be made on my behalf to Advantage Surgical & Wound Care. I also authorize any holder of Medicare information about me to release to my Medigap insurance carrier any information needed to determine these benefits for related services. Furthermore, understand that I am financially responsible to Advantage Surgical & Wound Care, for deductibles, co-insurance, and any outstanding balances that my insurance carrier deems to be my responsibility.

I have read the above and agree to abide by the terms and conditions put forth by Advantage Surgical & Wound Care.

The procedure has been thoroughly explained to me and I have had all the opportunities to have my questions answered. I consent to the procedure and terms outlined above:

_____ _____

Signature of Patient/POA Date

☐If Patient/ POA cannot complete form- verbal consent obtained in person or by phone

Telephone Number: _____ Relationship to Patient: _____

Response to Consent: _____

Signature of person placing call_____Witness:_____Date:_____

☐POA Documentation on File (if applicable) ☐Interpreter used (if applicable)

_____ _____

Eligible Provider or Clinician Signature Date

_____ _____

Witness Date

Advantage SURGICAL & WOUND CARE