Patient Wound Consent

_____ _____ _____ ____/____/_____ Gender_____ ____/____/_____

Last Name MI First Name Date of Birth Social Security

_____

Patient Residence | address Apt # City State Zip Code

_____ _____ _____

Location/Facility Name Home Phone Cell Phone

_____ _____ _____

Emergency Contact Person/Guardian Relationship to patient Emergency Phone

_____

Address Apt # City State Zip Code

***************************************Please fill above out completely before sending*************************************

Name of Primary Insurance Company Telephone Number Policy Number Group Number

_____ _____ _____ _____

Name of Secondary Insurance Company Telephone Number Policy Number Group Number

_____ _____ _____ _____

Responsible Party for Payment if other than Subscriber Name_____

_____

Address City State Zip Code

Person / Facility referring Patient_____

Contact Number_____

Type of Wound _____

Pharmacy_____

A KUT ABOVE MOBILE MEDICAL INC. 1785 WAVERLY PL SUITE A MELBOURNE FL, 32901
O: 321.216.2288 F: 321.216.2255 E: WOUNDCARE@AKUTABOVE.ORG

Patient Wound Consent

The Undersigned Patient or Authorized Patient Representative hereby consents to wound evaluation and treatment by A Kut Above Mobile Medical INC. The undersigned understands that this Consent Form will be valid and remain in effect from the date of the signature, for the duration the Patient receives care, treatment, and services with A Kut Above Mobile Medical INC. Patient or Authorized Patient Representative has the right to give or refuse consent to any proposed procedure or treatment at any me prior to its performance. .

1. General Description of Wound Care Treatment: The undersigned acknowledges that A Kut Above Mobile Medical INC. has explained the treatment for wound care, which can include, but not limited to: physical examinations, treatment, debridement, dressing changes, ordering of off-loading devices, diagnostic procedures such as x-rays, laboratory blood work, biopsy and wound cultures.

2. Benefits of Wound Care Treatment: The undersigned acknowledges potential benefits of wound care treatment elicit greater antibacterial benefit, pain reduction, less scarring, faster healing, neovascularization, and immune privilege.

3. General Risk of Wound Care Treatment: The undersigned acknowledges possible risk of wound care treatment includes but shall not be limited to: allergic reaction to wound care products, skin prep solutions, or local anesthetics. Risk of potential scarring, damage to blood vessels, tissue, nerves, bone, and/or organs that is inherent to wound care requiring procedures, particularly those with multiple medical conditions that compromise the vascular or immune system. Risk of excessive bleeding, removal of healthy tissue, ongoing pain, and inflammation. In severe cases, wounds that are infected may result in sepsis, loss of limb or death.

4. Consent to Photography of Wound(s): The undersigned agrees to the use of photography to assess, document, and treatment of wound(s).

5. Use and Disclosure of Protected Health Information (PHI): The undersigned voluntarily consents to the use of PHI such as the patient's medical history, demographic data, health insurance information, and wound images during wound care treatments. This information may be disclosed to affiliated companies or third parties for collaboration of care and billing purposes. Health history and photography may be utilized in case studies or education purposes. PHI shall be compliant with privacy regulations of the Health Insurance and Portability and Accountability Act of 1996 (HIPPA).

6. Financial Responsibility: The undersigned understands that the patient or responsible party hereby assigns insurance payments directly to A Kut Above Mobile Medical INC otherwise payable to the insured and is financially responsible for all charges whether paid by insurance.

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7. Patient/Caregiver is hereby informed of Medicare Advance Beneficiary Notice of Non-coverage (ABN). The ABN is a notice given to beneficiaries in Original Medicare to convey that Medicare is not likely to provide coverage in a specific case. “Notifiers” include: Physicians, providers (including institutional providers like outpatient hospitals), practitioners and suppliers paid under Part B (including independent laboratories); • Hospice providers and religious non-medical health care institutions (RNHCIs) paid exclusively under Part A; and • Home health agencies (HHAs) providing care under Part A or Part B. All of the aforementioned healthcare providers and suppliers must complete the ABN as described below in order to transfer potential financial liability to the beneficiary, and deliver the notice prior to providing the items or services that are the subject of the notice. Patient/Caregiver verbalized understanding of risks and benefits of wound care plan presented today. Patient/Caregiver is agreeable to wound care dressing changes, diagnostic testing, and treatment with advance dressings as applicable.

8. MEDICAL RECORDS RELEASE ASSIGNMENT OF BENEFITS I hereby authorize this office to release any necessary information for the purpose of payment of insurance claims. I hereby authorize the disclosure of my medical and insurance information to this office for the purpose of my care or to ensure payment from the insurance company. I hereby assign insurance payments directly to this office otherwise payable to the insured. I understand first I am financially responsible for all charges whether or not paid by my insurance. I agree to allow a copy of this authorization to be used in place of an original. This information may be faxed/mailed to : 1785 Waverly Place St A Melbourne FL 32901, Fax:311-218-2255

Printed Name of patient _____

POA/Guardian_____

Signature of the Patient/POA/Guardian:_____**Date:**_____

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