Guardian Healthcare Wound care

Intake Packet and Consents

Patient First Name: _____ Patient Last Name

_____Gender_____

Notice of Privacy Practices

HIPAA Privacy Rule of **Patient Authorization Agreement Authorization for the Disclosure** of Protected Health Information for Treatment, Payment. or Healthcare Operations (164.508(a))

This notice describes how health information about you may be used and disclosed and how you can gain access to this information. please review this notice carefully, the privacy of your health information is important to us.

OUR LEGAL DUTY

The Health Insurance and Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical and dental records and other Individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are properly kept confidential. HIPAA gives you the patient, significant rights to undemand and control how your health information is used.

HIPAA provides penalties for covered entities, including our Practice, that misuse of protected health information" (PHI). PHI is information about you. including demographic information, that may identify you and that relate to your past, present, or future physical or mental health or condition and related health care services. We are required by law to maintain the privacy of your PHI and to provide you with this notice of our legal duties and privacy practices with respect to your PHI. We also have a legal obligation to notify you in the event of a breach of unsecured PHI.

This Notice of Privacy Practices describes how we may use and disclose your PHI for treatment, payment, healthcare operations. and for other **purposes** that are permitted or required by law. It also describes your rights to access and control your PHI. This Notice of Privacy Policies takes effect from the date of signature and remains in effect until we replace it. We are required to abide by the terms of the Notice of Privacy Practices that is in effect.

We reserve the right to change our privacy practices and the terms of this Notice of Privacy Practices at any time. provided such changes are permitted by applicable law. We reserve the right to make any changes in our privacy practices effective for all PHI that we maintain, including health information we created or received before we made the changes. In the event of a change in our practices. we will provide you with a copy of the revised Notice of Privacy

Guardian Healthcare Wound care

Intake Packet and Consents

Patient First Name: _____ Patient Last Name

_____Gender_____

Practices through one or more of the following methods: posting the Notice of Privacy Practices to our website. mailing you a copy or providing you a copy at your next appointment with us.

You may request a copy of our current Notice of Privacy Practices at any time. For more information about our practices, or for additional copies. please contact us using the information Listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

Treatment: We may use or disclose your PHI to personnel in our office. as well as to physicians and other healthcare professionals within or outside our office. who are involved in your medical care and need the information to provide you with medical care and related services. For example, we may use or disclose your PHI in consultations and or discussions regarding your medical care and related services with healthcare providers who we refer to and receive referrals from. We require authorization to disclose your PHI to healthcare providers not currently involved in your care.

Payment: We may use and disclose your PHI to obtain payment for services we provide to you. If you personally pay in full for service(s), you have the right to restrict us from disclosing your PHI with respect to that service(s) to your health plan/insurer. For example, we may give your health insurance provider information about you so that they will pay for your treatment.

Healthcare Operations: We may use and disclose your PHI in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation. certification. licensing. and credentialing activities.

For example,

We may disclose PHI to medical students who are performing work with our office, or calf your name in the reception area.

Appointment Reminders and Other Contacts: We may disclose PHI in the course of leaving phone messages and in providing you with appointment reminders via phone messages, postcards, or fetters. We also may use and disclose

Guardian Healthcare Wound care

Intake Packet and Consents

Patient First Name: _____ Patient Last Name

_____Gender_____

Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Business Associates: We may disclose PHI to our business associates, such as billing services or healthcare professionals providing services as independent contractors. for the purpose of performing specified functions on our behalf and/or providing u! with services. PHI will only be used or disclosed if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of PHI and are not allowed to use or disclose any PHI other than as specified in our contract with them.

Your Family, Friends. and Representatives: We may use or disclose PHI to notify or assist in the notification of a family member, domestic partner, close personal friend, your personal representative, an entity assisting in a disaster relief effort or another person responsible for or involved in your care. If you are present prior to use or disclosure of PHI we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity, your death or in emergency circumstances. if deemed appropriate based upon our professional judgment. we will disclose PHI that is directly relevant to the person's involvement in your care. We may inform such person(s) of your location, your general condition, or death. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing person to obtain prescriptions, medical supplies, x-rays. or other similar forms of PHI on your behalf. We will not disclose PHI to such an individual if doing so would be inconsistent with any of your prior wishes that are known by us.

Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the victim of other crimes. We may disclose your PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Coroners, Medical Examiners and Funeral Directors: We may release PHI to coroners or medical examiners as necessary, for such purposes as identifying a deceased person or determining the cause of death. We also may release PHI to funeral directors as necessary for their duties.

National Security: Under certain circumstances, we mav disclose PHI to military authorities. We may disclose PHI to authorized federal officials as required for lawful intelligence, counter-intelligence, and other national security

activities. Under certain circumstances. we may disclose PHI to a correctional institution or law enforcement official with whom you are in lawful custody. Fundraising: We may contact you in relation to fundraising activities. however, you have the right to opt out of receiving such communications.

Data Breach Notification Purposes: We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your PHI.

Required by law: We may use or disclose your PHI when we are required to do so by taw. Such circumstances include, but are not limited to, compliance with a court order, mandatory reporting due to serious or imminent threats to the public, mandatory reporting of child abuse or neglect, in response to government agency audits or investigations. and reporting disclosures to the Secretary of the Department of Health and Human Services as necessary for the purpose of investigating or determining our compliance with HIPAA and Health Information Technology for Economic and Clinical Health Act (HITECH) rules.

YOU MAY PROVIDE ADDITIONAL AUTHORIZATION

Marketing Uses: We may only use or disclose your PHI for marketing purposes if you authorize us to do so. Such authorization would allow us to disclose PHI to a third-party vendor business associate for the purpose of providing you with targeted supplementary products or services when your physician believes such offerings will be of value to you. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

Sale: We may only use or disclose your PHI in a manner that constitutes a safe of information if you authorize us to do so. Your authorization may be revoked in writing at any time. Revocation of authorization will not affect any use or disclosures permitted by your authorization while it was in effect.

To Others Upon Your Specific Authorization:

In addition to our use of PHI as described in this Notice of Privacy Practices, you may

give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization white it was in effect. If the Practice maintains any psychotherapy notes, they will not

Guardian Healthcare Wound care

Intake Packet and Consents

Patient First Name: _____ Patient Last Name

_____Gender_____

be released unless you sign an authorization or if otherwise required by law. Consistent with the Genetic Information Nondiscrimination Act (GINA)our Practice will not use or disclose your genetic information to insurance providers or others for underwriting purposes.

PATIENT RIGHTS

Access: You have the right to inspect and receive copies of your PHI, or to receive your PHI electronically. with limited exceptions. You may also request that we prepare a summary or an explanation of your PHI. If we maintain your PHI in electronic format, you may request to view your PHI in that format. You may request that we provide copies or the summary in a format other than photocopies. We will use the format you request unless it is not practicable. To obtain copies or a summary. you must make a request in writing and provide us a reasonable amount of time to respond. genera\\y thirty (30) days. You may send a letter to or request a form from us using the contact information listed at the end of this Notice of Privacy Practices. We will charge you a reasonable cost-based fee for expenses such as copies, postage, scanning cost, electronic data compilation costs, and/or staff time. Contact us using the information listed at the end of this Notice of Privacy Practices for a full explanation of fees for your request.

Notification of a Breach: We with notify you of a breach of your unsecured PHI, as required by HIPAA and the Health information

Technology for Economic and Clinical Health Act (HITECH).

Disclosure Accounting: You have the right to receive a list of instances, if any, in which we or our business associates or their subcontractors disclosed your PHI for purposes other than treatment, payment. healthcare operations, and other permitted uses as described in this Notice of Privacy Practices, for the last 3 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests. You have the right to request such an accounting in an electronic format.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions. but if we do, we will abide by our agreement, except in emergency circumstances.

Guardian Healthcare Wound care

Intake Packet and Consents

Patient First Name: _____ Patient Last Name

_____Gender_____

Electronic. Alternative, or Confidential Communication: You have the right to request, in writing, that we communicate with you about your PHI by alternative means, such as in electronic format or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation regarding how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request. in writing, that we amend your PHI. Your request must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice of Privacy Practices on our website or by e-mail. you are entitled to receive a copy in written form.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment. and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care:
- a source of information for my diagnosis and surgical information to my bill:
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals. I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & HIPAA AGREEMENT

Patient Signature: _____ Guardian Health Wound care Rep_____

Guardian Healthcare Wound care

Intake Packet and Consents

Patient First Name: _____ Patient Last Name

_____Gender_____

Consent For Debridement

Reason for procedure/diagnosis: **Preparation for application of amniotic membrane** graft for non-healing wound.

Description of the Procedure:

This procedure Involves removing dead, inter damaged tissue or foreign objects from a wound. This is called debridement. This procedure will expose healthy tissue to Improve heating. This may be done in various ways:

- Surgical debridement - A scalpel, scissors. or other tools will be used to remove unhealthy tissue or objects from the wound.
- Chemical debridement - A solution containing enzymes will be applied to the wound. The enzymes will digest the dead tissue
- **Mechanical debridement** - A wet dressing will be applied to the wound. As it dries, the dressing will stick to the dead tissue. The dressing will be moistened again and removed, taking the dead tissue with it.
- **Ultrasound Debridement** - Low frequency ultrasound to the treatment site using non-contact fluid (normal saline). Ultrasound-generated mist used to promote wound healing through wound cleansing and maintenance debridement by the removal of tissue exudates, bacteria, yellow slough and fibrin.
- Autolytlc debridement - Your body's own enzymes will dissolve the dead tissue. This is done by keeping moist dressings on the wound. This method is not used for infected wounds.

Aher the procedure. the open wound wilt be covered with amniotic membrane graft. It will then be covered with a loose dressing. Your provider may close the wound with stitches, staples, strips of tape, or other ways. This is called a secondary closure. The wound will gradually close on its own.

You may need additional procedures or surgeries to complete the debridement or close the wound.

II. Documentation of Informed Consent

1. I understand that the potential benefits and outcomes of the proposed procedure or treatment include but are not limited to: **This procedure may remove the dead tissue.** It may help the wound heat faster. It may help to prevent infection. It may relieve **pain. reduce fever, and improve** overall health.

Guardian Healthcare Wound care

Intake Packet and Consents

Patient First Name: _____ Patient Last Name

_____Gender_____

2. I understand that the potential risks and complications associated with the proposed surgery, procedure or treatment include but are not limited to:

- Bleeding.
- Pain or discomfort during or after the procedure.
- Pain, numbness, swelling, weakness, or scarring where tissue is cut.
- Scar(s). Scars may be painful. They may Limit function or range of motion. They also may not look the way you want them to
- Slow healing of wounds.
- The procedure mav need to be repeated.
- The procedure may not cure or relieve your condition or symptoms. They may come back and even worsen.
- Reactions to medicine(s) given or used during or after the procedure.
- You may need additional tests or treatment.
- Wound Infection, poor healing or reopening of the incision(s). Blood or clear fluid can also collect at the wound site(s). Infection may require antibiotics and additional surgery.
- An abscess or buildup of pus may form. It may require drainage or additional surgery.
- Damage to nerves, blood vessels, and other structures surrounding the treatment area.
- Sepsis, a dangerous infection of the blood or other tissues.

3. Alternatives to the proposed surgeries, procedures and treatments for my condition, including the benefits and risks of each and the option of no treatment, have been discussed with me. These include but are not limited to:

- Watching and waiting with your doctor.
- Topical treatments.
- Amputation if the wound affects an extremity.
- You may choose not to have this procedure.

4. It has been explained to me that sometimes during surgery, it is discovered that additional surgery is needed. If.

Guardian Healthcare Wound care

Intake Packet and Consents

Patient First Name: _____ Patient Last Name

_____Gender_____

in the opinion of the physician who is operating, I need such additional surgery, I permit the physician to proceed.

5. I have fully disclosed in my patient intake form any medications, previous complications, planned or previous surgeries.

sensitivities, allergies or current conditions that may affect this procedure.

6. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained from this procedure.

7. I have received and will follow the aftercare instructions as it is crucial to do so for good healing and to minimize the risk of complications.

8. I hereby consent to performing this, and all subsequent procedures set forth above, with any risks understood. I hereby release the physician. nurses, physician assistants, the clinic facility and Guardian Health Woundcare from any liability associated with this procedure.

9. It has been explained to me in a way that I understand: (i) The procedure undertaken: (ii) there may be alternative procedures or methods of treatment: and (iii) there are risks. known and unknown, to the procedure proposed.

10. I understand that I may be photographed and/or filmed during the course of my operation or treatment for my own diagnosis or treatment purposes. These photographs and/or films are intended for my medical record. They will be identified by my name and will not be released or used without my consent unless otherwise permitted by law. I understand that the photographs and/or films may also be used solely by Guardian Health Wound care for educational and research purposes. My name will not be placed on photographs and/or films released or used for educational and research purposes.

11. I authorize the provider and Guardian Health Wound care to preserve far scientific research or teaching purposes, or to dispose of any tissues. Body parts, or organs removed as a necessary part of my care according to hospital policy. (Send a copy of any exceptions to Department of Pathology.)

12. I understand that at the request of my physician, a vendor or medical equipment representative may be present during the performance of my procedure. Their presence shaft be limited to providing information for coordination of

Guardian Healthcare Wound care

Intake Packet and Consents

Patient First Name: _____ Patient Last Name

_____Gender_____

treatment and technical expertise on the use and operation of the vendor's device under the supervision of my physician.

13. I understand that each practitioner will have the appropriate skill sets to participate in any procedure and will be under the supervision of Guardian Health Wound care. I understand the names of other practitioners and the tasks they performed will be documented in the medical record.

III. Serial Procedures

I understand that I will receive a series of the same treatments over a time period not to exceed 180 days.

From: To

MM / DD / YYYY MM / DD / YYYY

If applicable. please indicate dates for serial procedures:

IV. Client Acknowledgement and Release

Guardian Healthcare Wound care

Intake Packet and Consents

Patient First Name: _____ Patient Last Name

_____Gender_____

This procedure has been recommended to you in the belief that it is of potential benefit in these circumstances and will quite probably improve the conditions for which you are under treatment and in your overall health. Based on the risks and potential benefits of the current medically indicated procedure(s) and of this proposed procedure, I assume full liability for any adverse effects that may result from the non-negligent administration of the proposed procedure. I waive any claim in law or equity for redress of any grievance that I may have concerning or resulting from the procedure, except as that claim pertains to negligent administration of this procedure. The risks involved and the possibilities of complications have been explained to me.

Therefore, in consideration for any treatment received, I agree to unconditionally defend hold harmless and release from any and all liability the company's and the individual that provided my treatment, the insured, and any additional insured, as well as any officers. directors. independent contractors, or employees of the above referenced companies for any condition or result, known or unknown, that may arise as a consequence of any treatment I may receive.

I understand and agree that any legal action of any kind related to any treatment I received will be limited to binding arbitration pursuant to the Arbitration Agreement.

V. Other

I understand that students, physician in training, associates, assistants, and other personnel may participate in my care and treatment.

Patient Signature: _____

Guardian Healthcare Wound care

Intake Packet and Consents

Patient First Name: _____ Patient Last Name

_____Gender_____

Arbitration Agreement for Claims Arising Out of or related to Medical Care and Treatment

BY SIGNING THIS AGREEMENT. YOU ARE WAIVING YOUR RIGHT TO A JURY TRIAL AND YOU AREAGREEING TO ARBITRATE ALL CLAIMS ARISING OUT OF OR RELATED TO YOUR MEDICAL CARE AND TREATMENT.

1. AGREEMENT TO ARBITRATE CLAIMS REGARDING FUTURE CARE AND TREATMENT: The patient agrees that any controversy, including without limitation, claims for medical malpractice, personal injury, loss of consortium, or wrongful death, arising out of or in any way relating to the diagnosis. treatment, or care of the patient by the undersigned provider of medical services, including any partners. agents, or employees of the provider of medical services, shall be submitted to binding arbitration.

2. AGREEMENT TO ARBITRATE CLAIMS REGARDING PAST CARE AND TREATMENT: The patient further agrees that any controversy, including without limitation, claims for medical malpractice, personal injury, loss of consortium or wrongful death arising out of or in any way relating to the past diagnosis. treatment. or care of the patient by the undersigned provider of medical services or the provider's partners. agents or employees. shall be submitted to binding arbitration.

3. WAIVER OF RIGHT TO JURY TRIAL: BOTH PARTIES TO THI5 AGREEMENT, BY ENTERING INTO IT. ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

4. ALL CLAIMS MUST BE ARBITRATED BY ALL CLAIMANTS: All Claims based upon the same occurrence, incident, or care shall be arbitrated in one proceeding. It is the intention of the parties that this Agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the provider of medical services, including the patient, the patient's estate. any spouse or heirs of the patient, and any children of the patient.

Patient First Name: _____ Patient Last Name

_____Gender_____

whether born or unborn, at the time of the occurrence giving rise to the claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. Bv signing this Agreement, the parties' consent to the participation in this arbitration of any person or entity that would otherwise be a proper additional party in a court action.

5. ARBITRATION PROCEDURES: The parties agree and recognize that the substantive provisions of the State of Tennessee laws, rules and regulations governing medical malpractice claims shall apply to the parties and/or claimant(s) in all respects, except that at the conclusion of the pre-suit screening period and provided there is no mutual agreement to arbitrate under Tennessee laws, rules and regulations. (which remain available if elected by the parties), the parties and/or claimant(s) shall resolve any claim through arbitration pursuant to this Agreement. Within thirty (30) days after a party to this Agreement has given written notice to the other of a demand for arbitration of said dispute or controversy under this Agreement, the parties to the dispute or controversy shall each appoint an independent arbitrator who is a member of the American Health Lawyers Association and give notice of such appointment to the other. Within a reasonable time after such notices have been given the two arbitrators so selected shall select a neutral arbitrator. who shall be an attorney and member of the American Health Lawyers Association and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator. The parties agree that the arbitration proceedings are private. not public, and the privacy of the parties and of the arbitration proceedings shall be preserved.

6. ARBITRATION EXPENSES: Each party shall bear the cost of her/its own attorneys' fees, the costs of presenting her its case, and her its arbitrator. Any cost associated with the neutral arbitrator shall be shared equally by the parties, to the extent not provided by the State Department of Administrative Hearings. Other costs of the arbitration (e.g. of securing a location for the arbitration, court reporter. etc.) shall be share by the parties.

7. APPLICABLE LAW: This Agreement shall be governed by and construed and enforced under the laws of the State of Tennessee.

Any controversy or claim arising out of or relating to this contract, or the breach thereof, shall be settled by arbitration in the State of Tennessee, before a single arbitrator, in accordance with the Rules of Procedure for Arbitration of the

Guardian Healthcare Wound care

Intake Packet and Consents

Patient First Name: _____ Patient Last Name

_____Gender_____

American Health Lawyers Association (AHLA) Alternative Dispute Resolution Service, and judgment upon the award rendered by the arbitrator(s) shall be entered in any court having jurisdiction thereof. For the purpose of entering such Arbitration Award as a State Court Judgment. the parties hereto consent to the jurisdiction and venue of an appropriate court located in the State of Tennessee. A party may initiate such arbitration by making written demand for arbitration on the other party. The demand shall contain a statement setting forth the nature of the dispute, the amount of damages involved, if anv and the remedies sought. The parties agree that only claims asserted pursuant to this agreement will be arbitrated in a proceeding initiated under this section and such claims shall not be consolidated or coordinated in any arbitration action with the claim of any other individual or entity. No claim may be arbitrated on a coordinated, class, mass, collective or consolidated basis. No claim may be brought as a class action or as a private attorney general. In no event will this arbitration clause be interpreted to allow a class action in arbitration. The actual cost of the arbitration. including the fees of the arbitrator(s) shall be borne equally by the parties. In the event that Arbitration (or litigation) relating to domestication of Arbitration Award) results from or arises out of this Agreement or the performance thereof, the parties agree to reimburse the prevailing party's reasonable attorney's fees, court costs. and all other expenses. whether or not taxable by the court as costs, in addition to any other relief to which the prevailing party may be entitled. In such event, no action shall be entertained by said court or any court of competent jurisdiction if filed more than one (1) year subsequent to the date the cause(s) of action actually accrued regardless of whether damages were otherwise as of said time of care.

B. **EFFECT OF REFUSAL TO PROCEED WITH ARBITRATION:** In the event that any party to this Agreement refuses to go forward with arbitration, the party compelling arbitration reserves the right to proceed with arbitration, the appointment of an arbitrator, and hearings to resolve the dispute, despite the refusal to participate or absence of the opposing party. Submission of any dispute under this agreement to arbitration may only be avoided by a valid court order. indicating that the dispute is beyond the scope of this Agreement or contains an illegal aspect precluding the resolution of the dispute by arbitration. Any party to this Agreement who refuses to go forward with arbitration hereby acknowledges that the arbitrator will go forward with the arbitration hearing and render a binding decision without the participation of the party opposing arbitration or despite that party's absence at the arbitration hearing.

Guardian Healthcare Wound care

Intake Packet and Consents

Patient First Name: _____ Patient Last Name

_____Gender_____

9. **SEVERABILITY:** If any provision of this Agreement is held invalid or unenforceable, the remaining provisions shaft remain in full force and shall not be affected by the invalidity of any other provision.

10. **ACKNOWLEDGEMENTS BY PATIENT:** The patient. by signing this Agreement. also acknowledges that he or she has been informed that:

a. **NO DURESS:** The Agreement may not be submitted to a patient for approval when the patient's condition prevents the patient from making a rational decision whether or not to agree;

b. **AGREEMENT BASED UPON OWN FREE WILL:** The decision whether or not to sign this Agreement is solely a matter for the patient's determination without any influence by the medical provider:

c. **BINDING ARBITRATION AND EFFECT ON RIGHT OF APPEAL:** Binding arbitration means that the parties give up their right to go to court to assert or defend a claim covered by this Agreement. The resolution of claims covered by this Agreement will be determined by a neutral panel of arbitrators and not a judge or jury. Each party is entitled to a fair hearing, but the arbitration procedures are simpler and more limited than rules applicable in court. Arbitration decisions are as enforceable as any court order. The decision of an arbitration panel is final and there will generally be no right to appeal an adverse decision. However. anv party may within 15 days from a decision of an arbitration panel, file a written request for reconsideration. Any such request for reconsideration shall be based upon (i) a claim that the panel failed to properly apply the law or applicable rules of evidence or (ii) that the procedures specified in this Agreement were not followed. A claim that the panel was incorrect as to the facts, or gave undue weight to certain evidence will not be a basis for a request for reconsideration; and

d. **SIGNATURE OF AGREEMENT:** This Agreement shall be effective upon the patient's and/or the patient's representative's signature below. Upon such signature. this Agreement shall be deemed to be fully executed and binding upon all parties.

IN WITNESS WHEREOF, the undersigned have caused this Agreement to be executed and delivered as of this date.

Clinic Name: Guardian Health Wound-care

Representative

Guardian Healthcare Wound care

Intake Packet and Consents

Patient First Name: _____ Patient Last Name

_____Gender_____

Signature_____

Name of Patient (or Representative) _____

Signature **of Patient (or)_____**

Patient (or Representative) _____

Guardian Healthcare Wound care

Intake Packet and Consents

Patient First Name: _____ Patient Last Name

_____Gender_____

VI. Consent

Consent expires 30 days after patient signature, except for serial procedures with documented dates above.

I have had the opportunity to ask questions: and my questions have been answered to my satisfaction. I understand the risks. benefits, and alternatives associated with the proposed operation. procedure or treatment. I consent to the operation. Procedure or treatment to be performed. ,

Signature of Patient or Designated Decision Maker

Sign here if verbal consent was obtained.

Guardian Health Wound-care _____Patient (or Representative) _____

In consideration of services, assignment of benefits and care rendered: I agree that I am responsible for any and all charges biked by the above-named clinic (the "Physician") with respect to such services and care unless the contract between the Physician and my insurance company provides otherwise. In the event that the requested services are not specifically authorized by my insurance company, I agree to pay for all services as agreed upon, unless otherwise provided by law.

I authorize payment of medical benefits to which I am entitled directly to the Physician, to cover the cost of the care and treatment rendered to myself or my dependents in the office.

Upon receipt of a medical Bill I agree to immediately pay off amounts not covered by insurance. If any insurance I currently have rejected my claim or pays part of the claim. I shall be responsible for payment of any balance as determined by Physician immediately after learning of such coverage, unless otherwise provided by law.

By signing this Financial Consent Form. I consent and accept to on\y receive medical invoices resulting from Physician providing medical care and treatment, electronically via PDF through the Guardian Health Wound-Care Portal (the •EMR Portal"),

This Declaration of Consent waives my legal right to receive medical invoices via regular mail including but not limited to, UPS, FedEx, UPS, among others. By signing this Agreement. I agree that I am responsible for reviewing my invoices electronically via the EMR Portal and for payment of any outstanding balance to cover the cost of the

Guardian Healthcare Wound care

Intake Packet and Consents

Patient First Name: _____ Patient Last Name

_____Gender_____

care and treatment rendered to myself or my dependents in the office.

I hereby consent with Physician's Financial Po\icy and Consent Form, with the above understood. I hereby waive my legal right to receive medical invoices via regular mail and therefore, agree and approve to sole\y receive medical invoices via the EMR Portal. I fully understand it's my responsibility to review/check the EMR Portal in a monthly basis and pay for all services as agreed upon, unless otherwise provided by law.

I acknowledge that I have been provided a copy of the Notice of Privacy Practices, HIPPA agreement and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time. that I will be provided with a copy of an updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices and HIPPA Agreement.

Signature of Patient **or Patient's** Representative_____

Debridement Consent

Signature of Patient **or Patient's** Representative_____

I. Information Provided

I have been informed that the procedure or treatment to be performed is: Wound Debridement.