SANDY SPRINGS
HYPERBARIC PHYSICIANS
OF GEORGIA

Your Partners In Healing

5665 Peachtree Dunwoody Road,
Suite G9, Atlanta, GA 30342

678-229-2800 ♦ Fax: 404-845-9989

.hbomdga.com

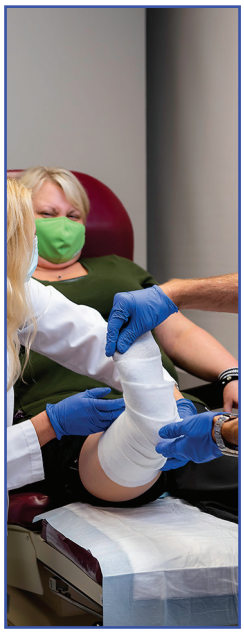
David Beless, MD
Medical Director

PATIENT GUIDE TO WOUND CARE TREATMENT

NOTE:

Patient hereby voluntarily consents to wound care treatment by physician, facility and their respective employees, agents, representatives, (hereinafter sometimes collectively referred to as the "practice"). The patient has the right to give or refuse consent to any proposed procedure or treatment at any time before its performance.

This form is to be signed by all wound care patients or their legal representatives. If patient is going to receive hyperbaric oxygen therapy, the patient must also execute the "**Patient Guide to Hyperbaric Oxygen Therapy**" consent form.



1. General Description of Wound Care Treatment:

Wound care treatment may include, but shall not be limited to: debridements, 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, hyperbaric oxygen therapy, other imaging studies and administration of medications prescribed by a physician.

2. Benefits of Wound Care Treatment:

The benefits of wound care treatment include enhanced wound healing and the reduced risks of amputation and infection.

3. Risks/Side Effects of Wound Care Treatment:

Wound care treatment may cause side effects. The risks include, but not be limited to: infection, ongoing pain, inflammation, potential scarring, possible damage to blood vessels, possible damage to surrounding tissues, possible damage to organs, possible damage to nerves, bleeding, allergic reaction to topical and injected local anesthetics or skin prep solutions, removal of healthy tissue, and prolonged healing or failure to heal.

4. Likelihood of achieving goals:

By following the plan of care, the patient is 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. Therefore, the patient specifically agrees that no representation made to him or her by the practice constitutes a warranty or guarantee for any result or cure.

5. Alternative to Wound Care Treatment:

The patient may refuse wound care treatment. If the patient refuses wound care treatment, he or she will not gain the potential benefits of treatment. Instead of wound care treatment, patients may continue a course of treatment with his or her physician or forgo any treatment altogether.

6. Risks/Side Effects of Alternative for Wound Care Treatment:

The risks of alternative wound care treatment include prolonged healing or failure to heal, increased potential for infection, and possible amputation.

7. General Description of Wound Debridements:

Wound debridement means the removal of unhealthy tissue from a wound to promote healing. During the course of wound care treatment, multiple wound debridements may be necessary. Our wound care physicians will perform the debridements.

8. 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, allergic reactions to topical and injected local anesthetics or skin prep solutions, excessive bleeding, infection, ongoing pain and inflammation, and failure to heal.

Drainage of an abscess or debridement of necrotic tissue may result in dissemination of bacteria and bacterial toxins into the bloodstream and thereby cause severe sepsis. Debridement may make the wound larger due to the removal of necrotic (dead) tissue from the margins of the wound.

9. Patient Identification and Wound Images:

Patient understands and consents that images (digital, film, etc.), may be taken of the patient and all associated wounds with their surrounding anatomic features. The purpose of these images is to monitor the progress of wound treatment and ensure continuity of care. Patient further agrees that their referring physician or other treating physicians may receive communications, including these images, regarding the patient's treatment plan and results. These images are considered protected health information and will be handled in accordance with federal laws regarding the patient privacy, security, and confidentiality of such information. Patient understands that the practice will retain the ownership rights to these images, but that the patient will be allowed access to view them or obtain copies according to state and Federal law. Patient understands that these images will be stored in a secure manner that will protect the privacy and that they will be stored appropriately for the period required by law. Patient waives all rights to royalties or other compensation for these images. Images that identify the patient will only be released and used outside the practice upon written authorization from the patient or patient's legal representative.

10. Use and Disclosure of Protected Health Information (PHI):

The patient consents to the practices use of PHI, results of a patient's medical history, physical examination, and wound images obtained during the patient's wound care treatment and stored in practice EMR. Disclosure of patient's PHI shall comply with the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Patient specifically authorizes use and disclosure of patient's PHI by the practice for purposes related to treatment, payment, and healthcare operations. If a patient wishes to request a restriction to how his or her PHI may be used or disclosed, the patient may submit a written request for restriction.

CONTACT INFORMATION:

The staff is available to handle routine questions or concerns, Monday - Friday, 7:00 a.m. to 3:30 p.m.
678-229-2800

AFTER HOURS PHONE:

After hours, call 770-423-2929. Answering service will answer. Inform the operator that there is a problem. Leave your name and contact number. The hyperbaric physician will be contacted and will return your call.

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WOUND CARE TREATMENT

Patient Last: _____ First: _____ MI: ____ Date of Birth: _____

Physician: ☐ Daniel Beless, MD ☐ David Schwegman, MD ☐ Timothy Hutton, MD ☐ Helen Gelly, MD ☐ Marina Wilder, MD
☐ Joni K. Hodgson, DO ☐_____

The patient hereby acknowledges that he or she has read or had this document read to them and agrees to its contents **(PATIENT GUIDE TO WOUND CARE TREATMENT)**. Patient agrees that his or her medical condition has been explained to him or her by the physician. Patient agrees that the risks, benefits and alternatives regarding all care, treatment, and services that patient will undergo have been discussed with patient by physician. Patient understands the nature of his or her medical condition, the risks, alternatives and benefits of treatment, and the consequences of failure to seek or delay treatment for any conditions. The patient has had the opportunity to ask questions of the physician and has received appropriate answers to all of his or her questions.

By signing below, I agree that: (1) My signature below constitutes acknowledgment that I have read and agree to the attached document, and that a physician has satisfactorily explained the care I will be receiving to me, I have received "**PATIENT GUIDE TO WOUND CARE TREATMENT**", and that I have all the information that I desire. (2) I grant permission to take medical photographs of my condition and hereby authorize the publishing or reproduction of such photographs for correspondence with my referring physician and for teaching/educational purposes. I understand that I will not be identified by name and that my anonymity will be preserved in any presentation or publication. (3) I consent to the transfer of health information protected by HIPAA for purposes related to treatment, payment, and health care operations. (4) Furthermore, I grant permission to take a photograph of myself for the purpose of patient identification. This photograph shall remain a permanent part of my patient record.

Patient understands that this *Consent Form* will be valid and remain in effect from the date of signature, as long as the patient receives care, treatment, and services at the practice. After a patient is discharged, and the patient returns for care, treatment, or service, a new consent form will have to be signed.

Missing your scheduled appointments can compromise the success of your ongoing care. Follow-up appointments are essential so that you and your physician can assess the progress of your treatment plan. It is also essential that you continue the prescribed plan until the treatment goals you and your physician have agreed upon have been accomplished, and until you and your physician formally agree to end your treatment. If you find you cannot keep a future appointment call the facility as soon as you can to reschedule.

_____ _____
Signature of Patient/Parent/Guardian or Authorized Representative *Date*
(Guardian or authorized representative must attach documentation of such status.)

_____ _____
Printed Name of Authorized Representative *Relationship/Capacity to Patient*

_____ _____
Witness Signature *Date*

_____
Printed Name of Witness

The undersigned physician has explained to the patient (or his or her legal representative), in layman's terms, the nature of the treatment, reasonable alternatives, benefits, risks, side effects, likelihood of achieving patient's goals, complications and consequences which are/or may be associated with the treatment or procedure(s).

_____ _____
Signature of Physician *Date*

ORIGINAL SIGNATURE STAYS IN PATIENTS CHART

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