SPECIALIZED WOUND MANAGEMENT

14805 N. Outer 40 Rd. Suite 320 Chesterfield, MO 63017
Phone: 888-811-4677 Fax: 800-605-8906 OR 636-536-0526

PATIENT/CLIENT RELEASE/AUTHORIZATION

Patient/Client Name_______________________________________Social. Sec#.__________________

Facility________________________ Email (for patient portal access)____________________________

REQUEST FOR SKIN/WOUND CONSULTATION/MANAGEMENT MEDICAL SERVICE

I understand that by signing this agreement, I authorize provision services from the company or its affiliates. Chronic wounds frequently have necrotic or non-viable tissue. Removal (debridement) of this tissue is a key component to wound healing. SWM. wound consultants may perform debridement of necrotic/devitalized tissue if necessary, using scalpel or curette. Topical or local anesthesia may be used if necessary. Although extremely rare, risks of sharp debridement may include infection, pain or bleeding.

MEDICAL SUPERVISION AND RESPONSIBILITY

I understand that I am under the care and supervision of my attending physician. I authorize my primary physician, consulting physician(s), medical facilities (if applicable) & SWM.to share pertinent medical information.

AGREEMENT TO PAY

In consideration for the company providing medical products, supplies and/or services as ordered by the patient/client and/or medical provider, I the undersigned agree that the responsibility for payment for any such products and services rests with me.

ASSIGNMENT AGREEMENT

I request that payment of authorized Medicare, Medicaid or other insurance be made on my behalf directly to the company for any medical products, supplies, or services rendered by the company. In the event payments of insurance benefits are made directly to me the payee will endorse to the company all checks for such payments.

RELEASE OF INFORMATION

I hereby authorize any holder of medical information about me to release to my insurance carrier or any agency or representative of said insurance company for the purpose of obtaining payment for services provided to me. I also authorize the review of my records including medical records by Federal, state, or accrediting body or agency. SWM. will not release my medical information to any other agent not listed above without my written permission. I have the right to review my SWM medical records on written request.

HIPAA/PATIENT CONSENT

SWM's Notice of Privacy Practices provides information about how SWM may use and disclose protected health information. By signing this form, I consent to the disclosure of protected health information about my treatment, payment and health care.

____ ____________________ __________
Patient/Client (Power of Attorney) Signature Relationship Date

Witness: ____ __________
Date

Verbal Consent:_______________________________________ __________
Date

Taken by:____ __________
Date