INFORMED CONSENT: WOUND CARE

1. I confirm that my Health Care Professional has discussed the available treatment options for my current diagnosis with me.
2. My Health Care Professional has also discussed with me the benefits, costs and risks associated with each treatment option.
3. I declare that I understand the various options, benefits and risks as outlined by the Health Care Professional and hereby provide informed consent for the use of the prescribed therapy, which includes the relevant consumables and loan equipment, if applicable as part of the treatment for the condition.
4. I understand that the treatment of my condition entails the consultation fees of the doctor, the costs of the prescribed treatment (which includes consumables and loan equipment, if applicable), as well as costs associated with hospital care and/or home nursing care (if applicable) and hereby provide my informed consent to the costs associated with the treatment.
5. I acknowledge that the fees and treatment costs, including the cost of the prescribed therapy and consumables actually incurred may differ from those reimbursed by my medical scheme, and I agree that I am liable for any shortfall in such instances.
6. I acknowledge that, should I be provided with loan equipment, that such equipment belongs to the manufacturing company, in spite of it being used as part of my treatment.
7. I hereby consent to the processing and disclosure of my healthcare and personal information and the taking of photographs for the purposes of motivating for medical scheme reimbursement and/or pre-authorization. Personal information will include the following, but not limited to:
   - Patient Full Name and Surname
   - Patient date of birth
   - Treating Doctor's Name, Surname and Practice Number
   - Medical Aid & Medical Aid Number
   - Full Delivery Address and contact telephone number
   - Hospital, ward
   - Type of consumables required
   - Type of therapy unit required
   - Patient's home address and contact telephone number
   - Wound/Treatment history, photo's and coding

   Personal information to be used only for order entry, order processing, order delivery, delivery of product ordered for a specific patient, invoicing to Insurance companies, complaints and disputes handling, answering questions received from patients and customer services, and IT data back-up.
8. The consent which I provided is to the specific therapy described above and that such information may not be used for any other purpose/s. I furthermore consent to the transfer of my healthcare and personal information outside of South Africa to a third party recipient(s) within the Acelity group of companies, as well as their duly appointed data operators, for the purposes of order entry, order processing, order delivery, delivery of product ordered for a specific patient, invoicing to Insurance companies, complaints and disputes handling, answering questions received from patients and customer services and IT data back-up
9. I acknowledge that, although pre-authorisation has been obtained or will be obtained for the treatment, the subsequent application of medical scheme rules or managed care processes may result in the decline or reversal of authorisation, and I undertake to address this issue with my medical scheme, should it arise. I also acknowledge that I have a right to appeal against any decision of my medical scheme, and after addressing the issue internally, that I have the right to complain at the Council for Medical Schemes:
   Email: Complaints@medicalschemes.com,
   Fax: (012) 431-0608
   Postal Address: Private Bag X34, Hatfield, 0028
10. I have been informed of the care required in relation to the treatment. I understand that, should I not adhere to the advice and instructions or the doctor and/or nursing staff, I cannot hold the practice, its staff and/or the manufacturers of any product or consumable liable for any harm that may flow from not following the said advice or instructions.

Signed at_____ on this _____ day of _____ 20____

Full Name and Surname of Patient: _____

Signature of Patient: _____

Contact Telephone Number: _____

Full Name and Surname of Next of Kin: _____

Signature of Next of Kin: _____

Contact Telephone Number: _____