INDY WOUND
CENTER FOR LIMB PRESERVATION & RECONSTRUCTION

PATIENT INFORMATION SHEET

Patient Name _____ **DOB** _____

Age _____ **Social Security#** _____ **Race** _____

Marital Status _____ **Gender** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Phone _____ **Primary Language** _____

Religion _____ **Referral Source** _____

Email _____

Employer _____ **Employer Phone** _____

Emergency Contact _____ **Phone#**_____

Primary Physician _____ **Phone#** _____

Referring Physician _____ **Phone#** _____

Primary Insurance _____ **Secondary Insurance** _____

ID# _____ **Group#** _____ **ID#**_____ **Group#** _____

Responsible Party _____ **DOB** _____ **Relation** _____

Pharmacy _____ **Address** _____

I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans, to this office. This assignment will remain in effect until revoked by me in writing. I understand I am responsible for all charges not paid by my insurance. I authorize this office to secure payment.

I authorize consultative services and related treatment by INDY WOUND CENTER FOR LIMB PRESERVATION & RECONSTRUCTION, this FACILITY, and its agents along with the release of any necessary medical information needed in my care, or in the processing of medical claims to INDY WOUND CENTER FOR LIMB PRESERVATION & RECONSTRUCTION, and its agents. I also assign the payment of medical benefits for the care and services provided to INDY WOUND CENTER FOR LIMB PRESERVATION & RECONSTRUCTION, this FACILITY, and its agents.

I certify that the information provided is true and correct to the best of my knowledge. I will notify INDY WOUND CENTER FOR LIMB PRESERVATION & RECONSTRUCTION and this FACILITY of any changes in the above information immediately.

_____

Signature of Patient/Guardian/Authorized Representative *Date*

8325 S Emerson Ave Suite B-1 Indianapolis, IN 46237 317-742-6575

INDY WOUND
CENTER FOR LIMB PRESERVATION & RECONSTRUCTION

MEDICAL AND SOCIAL HISTORY

CURRENT MEDICATIONS

Medicine	Dose	Frequency

Have you ever had any of the following conditions? Circle all that apply

Alzheimer's	Hearing Loss	Osteoporosis
Anemia	Heart Attack	Peripheral Artery Disease
Anxiety	Heart Condition	Phlebitis
Arthritis	Type:	Psychiatric Disorder
Ashtma	Hepatitis	Rheumatic Fever
Cancer _____	Type: A B C	Sciatica
Dementia	High Blood Pressure	Stomach Ulcer
Depression	Keloid/Thick Scar	Stroke
Diabetes: Type I Type II	Kidney Disease	Thyroid Problem
Insulin: Yes No	Dialysis Yes No	Tuberculosis
Onset:	Liver Disease	Venous Disease
Epilepsy	Lung Disease	Other _____
Glaucoma	Macular Degeneration	
Gout	Nerve Disorder	
Headaches		

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Are you slow to heal after cuts?	YES	NO	
Abnormal bruising, bleeding or scarring?	YES	NO	
Do you have vascular grafts/stents?	YES	NO	
Do you have joint implants?	YES	NO	
Do you have replacement heart valves?	YES	NO	
Do you have a pacemaker?	YES	NO	
Do you have a defibrillator?	YES	NO	
Are you under active chemotherapy?	YES	NO	
Do you have Sleep Apnea?	YES	NO	
Do you use CPAP or BiPAP machine?	YES	NO	
Have you had any other serious illness?	YES	NO	Please list _____
Current smoker?	YES	NO	
Alcoholic Beverages?	YES	NO	
Recreational Drugs?	YES	NO	

Please list any food or drug allergies _____

Family Health History – Please circle any that apply to your Mother, Father, Brother and/or Sister

Diabetes	M	F	B	S	Cancer	M	F	B	S
Arthritis	M	F	B	S	Heart Attack	M	F	B	S
Stroke	M	F	B	S	High Blood Pressure	M	F	B	S

CURRENT PROBLEM

Please describe your current problem: _____

_____

Circle all that apply:

Shooting Pain Burning Pain Tenderness Throbbing Pain

Itching Dull Pain Sharp Pain Aching Pain Tingling/Numbness

How long ago did the problem (pain) start? _____

Severity: Light Moderate Strong

List previous medical treatments for this issue by physician or home remedies:

_____

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NUTRITION

Is your wound non-healing/or has not improved in the past 3 weeks? YES NO
Have you lost weight over the past few weeks? YES NO

Height _____ Weight _____ lbs

Are you on a special diet? YES NO Please list _____

Please check any statements that pertain to you:

- I have an illness or condition that has made me change the kind and/or amount of food I can eat
- I eat fewer than 2 meals a day
- I eat less than 3 servings of fruit, vegetables, or milk products per day
- I have 3 or more drinks of beet, wine, and/or liquor almost every day
- I have mouth problems or teeth problems which make it difficult for me to eat
- I don't always have enough money to buy food
- I lie alone and/or eat alone
- I take medication which decreases my appetite and/or food intake
- Without trying, I have lost or gained more than 10 lbs
- I am not physically able to cook, shop, and/or feed myself

Are there any barriers to your treatment? Please check all that apply and explain:

- Transportation Explain _____
- Financial Explain _____
- Social Explain _____
- Environmental Explain _____

ADVANCED DIRECTIVES

Do you have advanced directives such as a Living Will, Power of Attorney for Health Care, and/or POST Form? YES NO

FUNCTIONAL STATUS

Do you need any help to walk or transfer into a chair? YES NO

Do you use any of the following to help you with mobility? Cane Walker Wheelchair/Scooter

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PATIENT BILL OF RIGHTS

As a patient, you have the following rights:

- Actively participate as a member of your wound care and/or hyperbaric medicine team if you are able and willing.
- Have your medical problem assessed and monitored by trained healthcare personnel.
- Have your questions about wound care and/or hyperbaric medicine answered openly and completely.
- Know what other treatment options are available to you.
- Know the benefits, risks, and side effects of your wound care and/or hyperbaric treatments.
- Receive timely and cost effective wound care and/or hyperbaric care.
- Seek other opinions about your wound care and/or hyperbaric related problem if you so desire and consult a specialist as necessary.
- Have your pain adequately controlled, under supervision of your primary physician.

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INDY WOUND
CENTER FOR LIMB PRESERVATION & RECONSTRUCTION

AGREEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing Indy Wound Center for Limb Preservation & Reconstruction as your medical provider. Below is our financial policy that requires your consent prior to treatment.

1. **Payment of your bill is part of your treatment and fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider.**

2. **All procedures, visits, dressing changes, diagnostic tests, facility charges, and services rendered will be filed with you insurance company.**

3. **You will be financially responsible for any balances not paid. By your insurance company including deductibles, copays, and coinsurance.**

4. **It is your patient responsibility to know if your insurance plan is a contracted provider with Indy Wound Center for Limb Preservation & Reconstruction. It is also your responsibility to understand your covered benefits and any services excluded from your plan as well as pre-authorization requirements for wound treatment services. Any out of network charges will typically be higher than an in network rate.**

5. **Eligibility with your insurance company will be checked by Indy Wound Center for Limb Preservation and authorization will be obtained for treatment when required. Please be advised that even with a pre-authorization, payment of benefits by your insurance company is not a guarantee.**

6. **Any change to your insurance must be given to the office.**

7. **If I am a "no-show" for an appointment or do not reschedule an appointment within seven (7) days, I will be billed a $50.00 "no show fee". Our office team may ask you to reschedule if you are more than fifteen (15) minutes late to your scheduled appointment.**

I have read the financial policy outlined above, and my signature below serves as an acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all charges in full.

Signature of Patient/Responsible Party *Date*

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Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed language as appropriate*]

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia,

pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed language regarding applicable state law requirements as appropriate*]

<u>When balance billing isn't allowed, you also have these protections:</u>

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact [*Insert contact information for entity responsible for enforcing the federal and/or state balance or surprise billing protection laws. The federal phone number for information and complaints is: 1-800-985-3059*].

Visit [*Insert website describing federal protections, such as www.cms.gov/nosurprises/consumers*] for more information about your rights under federal law.
[*If applicable, insert:* Visit [*website*] for more information about your rights under [state laws].]

INDY WOUND
CENTER FOR LIMB PRESERVATION & RECONSTRUCTION

In order to provide the best care to you and ensure you have all of the supplies you need, we have the ability to order and deliver your wound care supplies to your home. Below are the Medicare standards we follow to ensure you get the most of out of your care experience with us. Please ask us if you prefer this document in Spanish.

Medicare Supplier Standards

Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57(c).

1. A supplier must be in compliance with all applicable federal and state licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. An authorized individual (one whose signature is binding) must sign the enrollment application for billing privileges.
4. A supplier must fill orders from its own inventory or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs or from any other federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment and of the purchase option for capped rental equipment.*
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable state law and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site and must maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR 424.57 (c) (11).
12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items and maintain proof of delivery and beneficiary instruction.
13. A supplier must answer questions and respond to complaints of beneficiaries and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair directly or through a service contract with another company Medicare-covered items it has rented to beneficiaries.

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15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.
17. A supplier must disclose any person having ownership, financial or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number (i.e., the supplier may not sell or allow another entity to use its Medicare billing number).
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include the name, address, telephone number and health insurance claim number of the beneficiary; a summary of the complaint; and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services for which the supplier is accredited in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals).
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. A supplier must meet the surety bond requirements specified in 42 C.F.R. 424.57(c).
27. A supplier must obtain oxygen from a state-licensed oxygen provider.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516(f)
29. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
30. A supplier must remain open to the public for a minimum of 30 hours per week except physicians (as defined in section 1848 (j) (3) of the Act) or physical and occupational therapists or a DMEPOS supplier working with custom made orthotics and prosthetics.

My signature indicates that I have read and received the Medicare Supplier Standards and I understand that supplies will be billed to my insurance and sent to the address provided on file. I understand that I can decline this program as well and I will inform Indy Wound Center for Limb Preservation & Reconstruction in such cases.

Signature of Patient *Date*

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INDY WOUND
CENTER FOR LIMB PRESERVATION & RECONSTRUCTION

Your Information. Your Rights. Our responsibilities.

The Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can receive access to this information.

Your Rights

When It comes to your health information, you have certain rights.

- ***Receive an electronic or paper copy of your medical record.***
  - ***You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you.***
  - ***We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable fee.***

- ***Ask us to correct your medical record.***
  - ***You can ask us to correct health information about you that you think is incorrect or incomplete.***
  - ***We may say "no" to your request, but we will explain to you in writing within 6 days.***

- ***Request confidential communications.***
  - ***You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.***
  - ***We will say "yes" to all reasonable requests.***

- ***Ask us to limit what we use or share.***
  - ***You can ask us <u>not</u> to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.***
  - ***If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.***

- ***Get us a list of those with whom we've shared information.***
  - ***You can ask for a list of times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.***
  - ***We will include all of the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures. We'll provide one accounting a year for free will charge a reasonable, cost-based fee if you request another within 12 months.***

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- ***Get a copy of this privacy notice.***
  - ***You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.***

- ***Choose someone to act for you.***
  - ***If you have given someone healthcare power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.***
  - ***We will ensure the person has this authority and can act for you before we take any action.***

- ***File a complaint if you feel your rights are violated.***
  - ***You can complain if you feel we have violated your rights by contacting us using the information on page 1.***
  - ***You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S. W., Washington D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/HIPAA/complaints/.***
  - ***We will not retaliate against you for filling a complaint.***

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- ***In these cases, you have both the right and choice to us to:***
  - ***Share information with your family, close friends, or others involved in your care***
  - ***Share information in a disaster relief situation***
  - ***Include your information in a hospital directory***
  - ***Contact you for fundraising efforts***
  - ***If you are unable to tell us your preference, for example if you are unconscious, we may go ahead and share information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.***

- ***In these cases, we never share your information unless you give us written permission:***
  - ***Marketing purposes***
  - ***Sale of your information***
  - ***Most sharing of psychotherapy notes***

- ***In the case of fundraising:***
  - ***We may contact you for fundraising efforts, but you can tell us not to contact you again.***

Our Uses and Disclosures

We typically use or share your health information in the following ways:

- ***To share with other professionals who are treating you.***
- ***To run our practice, improve your care, and contact you when necessary.***
- ***To bill and get payment from health plans or other entities.***
- ***Top share in certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.***
- ***Health research.***
- ***To share information if state or federal laws require it, including with the Department of Health and Human Services to ensure we are complying with the federal privacy law.***
- ***To share information with organ procurement organizations, coroner, medical examiner, or funeral director when a resident passes away.***
- ***To share information for worker's compensation claims, law enforcement purposes, health oversight agencies, special government functions, and any administrative orders that are administered.***

We are required to share your information in other ways that contribute to the country's public health and research.
For more information see ***www.hhs.gov/ocr/privacy/HIPAA/understanding/consumers/index.html***

Our Responsibilities

- ***We are required by law to maintain the privacy and security of your protected health information.***
- ***We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.***
- ***We must follow the duties and privacy practices described in this notice and give you a copy.***
- ***We will not user or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.***

For more information see: ***www.hhs/gov/ocr/privacy/HIPAA/understanding/consumers/noticed.html.***

Changes to the Terms of this Notice: ***We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.***

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INDY WOUND
CENTER FOR LIMB PRESERVATION & RECONSTRUCTION

PATIENT ACKNOWLEDGEMENT FORM

I understand that Indy Wound Center for Limb Preservation & Reconstruction and this Facility may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information without my permission. I understand that sometimes the law may require the release of information without my permission in which these situations are very unusual.

Indy Wound Center for Limb Preservation & Reconstruction and this Facility have a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is available to all patients. I understand that I have the right to read the "Notice of Privacy Practices" before signing this Acknowledgment.

Indy Wound Center for Limb Preservation & Reconstruction and this Facility may update this Acknowledgement and "Notice of Privacy Practices". If I ask, Indy Wound Center for Limb Preservation & Reconstruction and this Facility will provide me with the most current "Notice of Privacy Practices".

Within the "Notice of Privacy of Practices" is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited access to my medical records, restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication by specified methods of communication or alternative location.

Indy Wound Center for Limb Preservation & Reconstruction and this Facility have established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgements, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs, etc. I will assist Indy Wound Center for Limb Preservation & Reconstruction and this Facility by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of Indy Wound Center for Limb Preservation & Reconstruction and this Facility's "Notice of Privacy Practices".

By signing below, I hereby authorize Indy Wound Center for Limb Preservation & Reconstruction to provide medical care and treatment as deemed necessary and appropriate. If the patient is a minor, the legal guardian/parent signs, and consents to treatment for the patient. I understand this signature is valid for all future treatments.

_____

Signature of Patient/Guardian/Authorized Representative *Date/Time*

_____

Printed Name of Authorized Representative *Relationship to Patient*

_____

Address and Telephone Number of Authorized Representative

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OPTIONAL

AUTHORIZATION AND CONSENT TO PHOTOGRAPH, RECORD, INTERVIEW AND PUBLISH INFORMATION, STATEMENTS OR IMAGES

I, _____ authorize Indy Wound Center for Limb Preservation and Reconstruction ("Indy Wound Center") to use and publish in any public manner the practice deems reasonably appropriate, my name, voice, photograph, likeness, quotes, stories and/or any other information, statements or images (collectively, "Personal Materials"):

1. For any commercial or non-commercial purposes, including but not limited to, marketing, advertising, fundraising, development, public relations, media relations, charitable, educational, and scientific purposes, and
2. In the form of print, audio, visual, and social media, including but not limited to, articles, blogs, websites, brochures, pamphlets, newsletters, flyers, posters, advertisements, newspapers, film, live or taped television transmission, videotape, radio broadcast, and Internet publication.

This authorization is subject only to the following limitations, if any:

The term "photograph," as used in this Authorization and Consent, means motion picture, still photography, or visual recording of any kind and in any format such as slides, negatives, prints, videotape, video disc, and any other means of recording and reproducing images, including composite or modified representations.

By signing this Authorization and Consent, I understand that once my information is published and in the public domain, my information may be re-disclosed and will not be protected under the Health Insurance Portability and Accountability Act of 1996, as amended. I hereby waive any right to compensation for such uses, and I and my successors or assigns hereby hold Indy Wound Center and its administrators, directors, officers, medical personnel, other employees or agents, and their successors and assigns harmless from and against any claim for any injury, and any compensation, resulting from the activities authorized by me.

This Authorization and Consent remains valid for ten (10) years from the date of signature unless revoked in writing. I understand that any such revocation will not affect the commencement, continuation, or quality of my treatment at Indy Wound Center. Any revocation will not have any effect on any action taken in reliance on this Authorization and Consent before the practice receives my written notice of revocation.

By signing below, I acknowledge that I have read and understood the above and agree to the terms of this Authorization and Consent.

Signature of Individual or Personal Representative or Parent or Legal Guardian (for minors) Date

Patient Name if a Minor

The parties agree that this agreement may be electronically signed. The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability and admissibility.