NEWCare
New England Wound & Ostomy Care

CONSENT FOR TREATMENT

Patient Name: _____ **DOB:** _____

This consent authorizes the providers of New England Wound Care, LLC to perform reasonable and medically necessary examinations, diagnostic testing, and treatment.

By signing below, you acknowledge and agree that:

1. This consent is continuous in nature and remains effective even after a specific diagnosis is made and a treatment plan is recommended.
2. This consent applies to treatment provided at this office or any satellite office under common ownership.

This consent shall remain in effect unless and until it is revoked in writing. You understand that you have the right to discontinue services at any time. You also have the right to discuss your treatment plan with your provider, including the purpose, potential risks, and benefits of any examination, test, or treatment. If you have questions or concerns regarding any recommended test or treatment, you are encouraged to ask for clarification before proceeding.

I voluntarily request a physician, and/or Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist along with other health care providers or their designees as deemed necessary, to perform reasonable and medically necessary examinations, testing, and treatment for the condition(s) for which I am seeking care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read, understand, and voluntarily consent to the statements contained herein.

I consent to the photography or video recording of procedures or treatments performed for medical, scientific, or educational purposes. I understand that a separate authorization will be required if any images that identify me are to be used for purposes other than my medical treatment. I further understand that New England Wound Care, LLC may dispose of any leftover tissue or may use or transfer such tissue for scientific, educational, or commercial purposes, and that my identity will not be disclosed.

Unless I have specifically refused blood or biological products, I consent to their use if the practitioner determines that the anticipated benefits outweigh the associated risks. The practitioner will determine the type and amount of blood or biological products based on my clinical needs. I understand the potential risks and benefits, which may include, but are not limited to, transmission of infectious diseases (such as hepatitis or HIV/AIDS), fever, allergic reactions, destruction of transfused cells, or, in rare cases, death.

_____ Date and Time: _____
(Patient or Authorized Representative Signature)

_____ Date and Time: _____
(Witness Signature)