Charleston
Wound Care

Patient Agreement

Date: _____

I understand that I am being seen for treatment in order to achieve the healing of my wound(s).

This treatment is known to be effective only when provided on a regular basis. Misses appointments, sporadic appointment attendance or failure to comply with the plan of care presented by my physician can result in less effective or ineffective therapy. Thus, I understand that in order for my treatment to be successful, it is important that I receive treatment as scheduled and follow the treatment instructions provided by Charleston Wound Care.

I agree to the following conditions: (Please initial each line signifying agreement.)

_____ I will attend my appointments as scheduled. If I am unable to appear for a scheduled appointment, I will notify the Charleston Wound Care staff by 8:00 AM that day and attempt to reschedule for that same day during regular business hours.

_____ I understand that after 3 missed appointments without proper notice, I will be charged a fee of $25 that must be paid before a new appointment can be scheduled.

_____ I will follow the treatment plan provided by the physician and staff and I will actively seek assistance when I find that I am unable to comply with the plan of care for any reason.

I agree to cleanse my wound and apply the dressing as directed by the physician and staff.
I agree to relieve pressure from my wound if prescribed by the physician.
I agree to use edema control methods if prescribed by the physician.
I agree to follow good health practices of diet and exercise as recommended by the physician.
I agree to actively work towards smoking cessation as this practice may prevent or slow healing.
I agree that I am responsible for notifying the Charleston Wound Care staff immediately if I have any questions or concerns regarding my wound and how I should care for it.

_____ I understand that a violation of any of these conditions may result in my discharge from the Charleston Wound Care program.

Patient Signature	Physician Signature
_____	_____
Date / Time:	Date / Time:
_____	_____

Dr. Christopher Michaelis, DO

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