Clinical Wound Solutions, LLC

Phone (866) 964-6337 www.clinicalwoundsolutions.com Fax (866) 994-6337

Wound Care Product Order Form

Rep Name:	*Date of Service:
*Patient Name:	*Date of Birth:
*Shipping Address:	*Phone Number:
	*Primary Insurance:
*Social Security Number:	*Secondary Insurance:

Patient's Medical Release and Signature

I hereby acknowledge that I can choose to obtain wound supplies by alternate means. My signature below signifies my selection of Clinical Wound Solutions, LLC for delivery of the wound care products in this order. I hereby authorize payment of medical benefits directly to Clinical Wound Solutions, LLC. I further authorize the release of any medical information necessary to determine the extent of third party coverage and for processing an insurance claim on my behalf. If my insurance does not pay Clinical Wound Solutions, LLC I am responsible for the outstanding balance. If my insurance does not honor this assignment, I agree to forward any payment which I receive as a result of products provided by Clinical Wound Solutions, LLC. I agree to all additional terms and conditions and the universal consent on the reverse side of this order form.

Patient Signature: ***Date:***

Starter Kit Given?	**YES** ☐	**NO** ☐		**Is Patient on Home Health?**	**YES** ☐	**NO** ☐
Cleaning Kit Needed?	**YES** ☐	**NO** ☐		**Patient Location?**	**HOME** ☐	**NH** ☐

*Wound #1 Location:				
L___________x W___________x D___________ (cm)				
Drainage:	*None*	*Small*	*Moderate*	*Heavy*
Debrided:	Sharp	Enzymatic	Mechanical	Autolytic
Duration of tx:		*15 Days*	*30 Days*	
Frequency:	*Daily*	*Every 2 day*	*Every 3 day*	*Wkly*

*Wound #2 Location:				
L___________x W___________x D___________ (cm)				
Drainage:	*None*	*Small*	*Moderate*	*Heavy*
Debrided:	Sharp	Enzymatic	Mechanical	Autolytic
Duration of tx:		*15 Days*	*30 Days*	
Frequency:	*Daily*	*Every 2 day*	*Every 3 day*	*Wkly*

*Wound #3 Location:				
L___________x W___________x D___________ (cm)				
Drainage:	*None*	*Small*	*Moderate*	*Heavy*
Debrided:	Sharp	Enzymatic	Mechanical	Autolytic
Duration of tx:		*15 Days*	*30 Days*	
Frequency:	*Daily*	*Every 2 day*	*Every 3 day*	*Wkly*

*Wound #4 Location:				
L___________x W___________x D___________ (cm)				
Drainage:	*None*	*Small*	*Moderate*	*Heavy*
Debrided:	Sharp	Enzymatic	Mechanical	Autolytic
Duration of tx:		*15 Days*	*30 Days*	
Frequency:	*Daily*	*Every 2 day*	*Every 3 day*	*Wkly*

None to Small
- ☐ Hydrogel (*Sheet or Gauze*) ________
- ☐ Amorphous Hydrogel ________
- ☐ Silver Hydrogel (*sheet or gel*) ________
- ☐ Gauze Pad (*4x4 or 2x2*) ________

Any Drainage
- ☐ Medfil Particles ________
- ☐ Prisma ________
- ☐ Promogran ________
- ☐ Other Collagen ________

Moderate to Heavy
- ☐ Calcium Alginate ________
- ☐ Calcium Alginate Rope ________
- ☐ Silvercel (*rope or sheet*) ________
- ☐ Maxorb AG (*rope or sheet*) ________

Other: ____________________

Any Drainage
- ☐ Kling *(3" or 4")* ________
- ☐ Kerlix *(Plain or AMD)* ________
- ☐ Paper tape *(1" or 2")* ________
- ☐ Transparent tape ________
- ☐ Medfix tape ________
- ☐ Bordered Gauze ________
- ☐ Coban (1 per week) ________
- ☐ ACE Wrap (1 per week) ________

Moderate to Heavy
- ☐ Foam (bordered) ________
- ☐ Mepilex Transfer ________
- ☐ Foam (non-bordered) ________
- ☐ Exudry ________
- ☐ ABD Pads ________

Other: ____________________

"I certify that the above mentioned product(s) is/are medically necessary for this patient. This form and any statement on my letterhead attached hereto has been completed and/or reviewed by me. The foregoing information is true, accurate, and complete."

*Physician Signature: ____________________ *Date: ________

*Physician Name: ____________________ *Phone: ________ *Fax: ________

*Physician Address: ____________________ *NPI: ________ *UPIN: ________

*Physician Address: ____________________

*Required Information: Subject to all consents, agreements, terms and conditions on reverse.

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CLINICAL WOUND SOLUTIONS LLC
UNIVERSAL CONSENT AND AGREEMENT

ASSIGNMENT OF INSURANCE BENEFITS STATEMENT AND RELEASE OF INFORMATION

I currently maintain Private Medical Insurance, Medicare, or Medicaid which will reimburse the charges for goods provided to me from Clinical Wound Solutions LLC (CWS). In consideration for those goods provided by CWS, I hereby assign, transfer and convey to CWS all if my right, title and interest in my Medical Insurance, Medicare, or Medicaid for medical expense reimbursement purposes, including, but not limited to adding dependent eligibility, and to have a policy continued or issued in accordance with the terms and benefits under any insurance policy continued or issued. Payment of deductible or co pay amount is due when the goods are ordered.

I hereby authorize CWS and any physician or other healthcare provider, who may treat me to release, for the purpose of billing and collecting, any and all pertinent information contained in my medical records, including HIV, to one another and/ or their billing agents, and third party payors responsible for payment of patient charges including but not limited to insurance companies, health benefit plans, employers involved in approval of benefit claims, government agencies or intermediaries representing any of the above. I specifically authorize CWS, Medicare, Medicaid, and JCAHO, or any other recognized accredation agency to periodically examine my records for the purpose of compliance with Medicare, Medicaid, and JCAHO standards or other agency standards.

FINANCIAL RESPONSIBILITY STATEMENT

I hereby assume full responsibility for and agree to pay all costs, charges and expenses incurred by me for the goods provided by CWS, and on an ongoing basis as goods are supplied. My obligation to pay accrues upon delivery of the goods. All amounts past due shall bear interest at 1.5% per month or at the highest rate permitted by law. In cases where Medicare or Medicaid coverage exists, applies, is assigned, and pays CWS agrees to accept the charge determination of Medicare or Medicaid respectively as the full charge determination payment for the goods supplied, and I am responsible for all deductible and co-insurance amounts and all unassigned or non-covered amounts for goods supplied. I agree to transfer immediately to CWS any payment made directly to me for the goods supplied. I agree to be responsible for the full amount of the charges if payment has not been made directly to CWS within ninety (90) days from the date the goods are supplied and all of the correct and complete information necessary to submit and successfully process a claim for the goods has been sent to my insurer. If my medical insurance coverage is not sufficient to satisfy such costs, charges, and expenses in full, or if I do not follow guidelines of my insurer and the resulting balance is not covered by the Assignment of Insurance Benefits, I will be fully responsible for payment of the balance due CWS. Failure to make payment due to CWS may result in my account being submitted for collection service, which I understand may affect my credit rating. In the event that external collection services become necessary to obtain payment, I agree to pay all such collection agency fees and costs and all attorney fees and costs as well as all court costs. This Agreement shall be governed and construed according to the laws of the State of Illinois without regard to its conflict of laws provision, and jurisdiction and venue shall lie exclusively with a court of proper jurisdiction in Cook County, Illinois.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDERS

I certify that CWS is my sole provider of the goods provided any that the goods are not to be provided by any other source, including home health care or any other supplier of the goods. I agree to pay for all supplies or equipment provided and agree to all of the financial responsibility statement; if I am on home healthcare and CWS is not paid.

CREDIT CARD AUTHORIZATION

I specifically agree to and authorize CWS to charge any credit card I may designate, or any replacement or substitute credit card, for all deductible amounts, all co-payment amounts, all amounts not covered paid by or reimbursed by insurance, Medicare, or Medicaid up to the full costs, charges, and expenses for all goods and for all amounts not covered and paid by insurance, Medicare, or Medicaid within ninety (90) days and for any amounts due and claims denied, disputed, or delayed in payment by any insurance Medicare, or Medicaid for any reason. This is a continuing authorization to CWS to charge to the designated credit card. I agree to designate a credit card to charge, and to provide my designated credit card information to CWS, within five (5) days. CWS is also authorized to contact me for the specific purpose of securing my credit card information.

Upon signing the front side of this Order Form, I acknowledge that I have read and understand the foregoing and accept its terms.

MASTERCARD AND VISA ACCEPTED

Revised - April 29, 2009