Patient Consent Form for Skin Substitutes

Patient Consent for Advanced Wound Care Therapy – Skin Substitutes

Patient Name: _____ PMC Member _____
Date of Birth: _____

Clinic: _____
Treating Physician: _____

I understand that I am being offered treatment using an advanced skin substitute as part of my wound care plan. The purpose of this treatment is to assist in healing my chronic wound.

I understand:

- The product may be derived from human or placental tissue
- It has been processed and sterilized to minimize risk
- My clinical team has determined that this is medically necessary
- Alternative options have been discussed
- I may ask questions and withdraw my consent at any time

I acknowledge that my insurance may not cover the full cost and that I have received information about potential out-of-pocket expenses if applicable.

Patient/Legal Guardian Signature: _____
Date: _____

Physician Signature: _____
Date: _____