Empire Wound Care Service Agreement This Service Agreement ("Agreement") is entered into on

[Date:_____**]** by and between **Empire Wound Care** ("Company") and

[Agency:_____] ("Agency") for the provision of wound care services, including the application of biologics and DME (durable medical equipment) dressings. Billing will be processed under *Medicare Part B and commercial insurance.*

1. Scope of Services: The Company agrees to provide the following services to patients referred by the Agency:

-Comprehensive wound care management, including assessments and development of treatment plans.
-Application of biologics (tissue-based products, growth factors) as clinically indicated.
-Provision of DME dressings and other wound care supplies as necessary.

2. Scheduling and Patient Visits: Verify patient eligibility for Medicare Part B and/or commercial insurance coverage, as applicable. - The Company will schedule the initial patient appointment within **48 hours** of receiving the referral from the Agency. - Patients will be seen once per week by the Empire Wound Care Provider for ongoing wound care and treatment monitoring, and the agency will follow up with the patient as recommended by the Empire Wound Care Provider. - Send patient records, treatment notes, and recommendations to the Agency via HIPAA-compliant methods within 24 hours after each patient visit.

3. Responsibilities of the Company: Provide wound care services and biologics in compliance with professional standards and all applicable regulations. - Ensure timely delivery of DME dressings and necessary supplies to patients. - Submit claims for services rendered to Medicare Part B and commercial insurance providers in accordance with billing regulations.

4. Responsibilities of the Agency: Refer eligible patients to the Company and ensure that all required documentation, patient demographics, and insurance information are provided. - Facilitate communication between the Company, patients, and any other necessary providers.

5. Billing and Payment: Billing and Payment: The Company will bill Medicare Part B and commercial insurance directly for services rendered. - The Agency will assist in ensuring that all required patient information and authorizations are submitted in a timely manner.

6. Compliance and Confidentiality: Both parties agree to comply with all federal, state, and local laws, including Medicare regulations and HIPAA (Health Insurance Portability and Accountability Act) requirements for protecting patient information. - The Company will maintain the confidentiality of

patient information and will only share records with the Agency via HIPAA-compliant communication methods.

7. Term and Termination: This Agreement shall remain in effect for a period of **12 months** and may be renewed automatically unless terminated by either party with **30 days** written notice. - Either party may terminate this Agreement immediately for cause, including non-compliance with the terms of the Agreement.

8. Indemnification: Both parties agree to indemnify and hold the other harmless from any claims, damages, or liabilities arising from non-compliance with the terms of this Agreement or any applicable regulations.

9. Governing Law: This Agreement shall be governed by the laws of the state of **CALIFORNIA**. Authorized Representative (Company):

10. Contract Clause – Text Messaging Consent: By entering into this Agreement, [_____] expressly consents and agrees to receive text messages from Empire related to the services provided under this Agreement. Such messages may include, but are not limited to, updates regarding patient care coordination, service availability, scheduling, and other operational matters. This consent satisfies the requirements of the Telephone Consumer Protection Act (TCPA) for express written consent. Agency acknowledges that it may withdraw this consent at any time by providing written notice to Empire.

Name: _____ Title: _____

Signature: _____ Date: _____

Authorized Representative (Agency):_____

Agency Name:_____

Agency Address:_____ City & State:_____

Zip Code:_____

Email Address:_____

Telephone Number:_____

Fax Number:_____

Empire Wound Care Representative: _____

Empire Wound Care Representative Signature: _____ Date:_____

Empire Wound Care
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