Patient Consent Contract

Authorization for Medical Treatment

PLEASE READ CAREFULLY –THIS IS A CONTRACT

I consent to receiving services at Gary Burnstein Community Health Clinic (GBCHC). This treatment may include assessment, routine diagnostic procedures, medications, and appropriate medical treatment as the attending Physician/Nurse Practitioner/Physician's Assistant considers necessary for my care. I understand the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of examination or treatment at this clinic.

I understand that the services I receive at GBCHC, or as a result of a referral from GBCHC, are being provided by health care practitioners and lay volunteers who are not receiving compensation and compensation will not be requested from any source. I understand, as provided by Federal and Michigan State law, that these volunteers are not liable for civil damages as a result of acts or omissions which may occur in providing services to me, except acts or omissions amounting to gross negligence or willful and wanton misconduct or were intended to injure me.

I understand that any verbally abusive or threatening behavior to the clinic staff is grounds for the termination of clinic services.

In the event that any agent of the GBCHC is contaminated in any way with my bodily fluids, blood samples will be drawn from both parties to test for communicable diseases.

In the event that a patient must cancel an appointment, **we request that all cancelations occurs 24 hours prior to your appointment.** I understand that three "**NO SHOW"** visits are grounds for termination of all clinic services.

To make sure that your health care is provided for in a timely manner, we need to make sure that **ALL REQUESTS FOR REFILLS** of prescriptions must be made by **MONDAY** of the week that they are due to expire. Do not call in a refill request if you are scheduled to see the Doctor.

My signature below constitutes my acknowledgement that I understand this request for consent and that I agree to its contents.

______________________________________	______________________________________
SIGNATURE OF PATIENT/RESPONSIBLE PARTY	**PATIENT NAME (PRINTED)**
______________________________________	______________________________________
SIGNATURE OF WITNESS	**DATE**

Revised Nov 2017