



Patient Consent Contract
Authorization for 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, dental care and appropriate medical treatment as the attending Physician/Nurse Practitioner/Physician’s Assistant considers necessary for my care. 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 money and will also not be requested from any source. I understand, as provided by Federal and Michigan State law, that these volunteers are not liable for lawsuits as a result of acts or oversight. With the exception of acts amounting to failure, willful and cruel behavior, or intentions to injure me.

Any verbally abusive or threatening behavior to the clinic staff is grounds for dismissal of clinic services.

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

In the event that a patient must cancel an appointment, **we request that all cancelations occur 48 hours prior to your appointment.** I understand that three “**NO SHOW**” visits are grounds for ending of all clinic services.

For medication refills: Please call 2 weeks before you run out of your medication(s) to ensure that your health care is provided without interruption.

By signing below, I state that I have read and agree with the terms of the contract above.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY

PATIENT NAME (PRINTED)

SIGNATURE OF WITNESS

DATE