General Consent and Disclosure

The information in this consent form is given so that you will be better informed about the health care services you will receive. After you are sure you understand the information which will be given about the services and if you agree to receive the services, you must sign this form to indicate that you understand and consent to the services.

NOTIFICATION: HealthPOiNT Clinics (hereinafter called "the Clinics") encourage individuals to seek a personal physician for periodic health examinations and for the treatment of medical or behavioral health problems. The Clinics' services are targeted primarily toward prevention of health problems among those who cannot access a physician. The Clinics cannot assume the responsibility for payment of medical or behavioral health care received outside the Clinics, including the delivery of babies, unless previous authorization has been given.

DISCLAIMER: Among their services, the Clinics utilize screening tests, which are a method of identifying individuals who are at risk for developing several common medical or behavioral health/substance abuse problems. Screening tests perform a valuable service in helping to find certain diseases/conditions early in their course. However, these screening tests do not cover all diseases/conditions, and they may miss some cases of diseases/conditions they are intended to find. They are not diagnostic and they do not constitute a complete exam.

GENERAL CONSENT: I give permission to the Clinics, their designated staff, and other medical personnel providing services under their sponsorship to perform physical assessments or examinations, conduct laboratory or other tests, give injections, medications, and other treatments, and render other health services to the patient identified on this form. *Behavioral Health treatment of a minor cannot be provided without consent of a legal authorized representative.*

INFORMED CONSENT: In addition to the above general consent, I ☐ **give** / ☐ **DO NOT give** permission to the Clinics, their designated staff, and other medical personnel providing services under their sponsorship to perform the following procedures: medications for tuberculosis and Hansen's Disease, immunizations, injectable medication for sexually transmitted diseases, family planning methods, PKU special counseling, behavioral health, substance abuse treatment, and HIV testing.

INFORMED UNDERSTANDING: I understand that there are certain hazards and risks connected with all forms of treatment, and that no warranty or guarantee has been made to me as to the result of cure from care and treatment provided.

RELEASE OF INFORMATION: I further understand that all Medical Records, Behavioral Health/Substance Abuse Records, and Social Service Records may be released to representatives of the United States Department of Health and Human Services and to representatives of programs or projects funded by this Department and other funding services sources for the purposes of determining contract compliance with Federal/State law and regulations.

QUESTIONS: I certify that this form has been fully explained to me, that any blank lines have been filled in, and that any questions I have had about the services have been answered to my satisfaction. I further certify that I have read the Patient and Clinic Rights and Responsibilities and accept that document.

EXPIRATION: I understand that this consent is valid and remains in effect as long as I am a patient of HealthPOiNT, until I withdraw my consent, or until HealthPOiNT changes its services and asks me to complete a new consent form.

SIGNATURES: *Fill blank lines with NA if not applicable.*

SECTION I:

Patient Name: _____ DOB: _____ Sex: _____

Patient Signature: _____

Person Authorized to Consent (if not patient): _____ Relationship: _____

Signature: _____ Date: _____

SECTION II:

Staff Member Name: _____

Staff Member Signature: _____ Date _____